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ABSTRACT

This report contains recommendations of a Wisconsin Task Assignment Steering Committee created to explore solutions to some significant problems facing adult chronic "revolving-detox-door" alcohol abusers (CRA's), persons with repeated admissions for detoxification services; and to examine the system that serves and funds them. This report is intended as a catalyst for the Wisconsin Department of Health and Social Services, other state agencies, legislative bodies and the Bureau of Alcohol and Other Drug Abuse delivery system to join forces in developing effective alternative approaches to serve the CRA. The nature and consequences of alcohol abuse are outlined and a case study of a typical CRA is provided. The majority of the report consists of analyses, discussions, and 26 recommendations concerning four major issues: (1) the need for a uniform definition of the CRA; (2) fiscal issues related to the CRA; (3) programming and services; and (4) training of health care professionals. A glossary provides definitions of terms used in the text, and appendices contain survey forms, record forms, data tables, and other related materials including a list of the eight specific objectives of this Task Assignment. (NRB)

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AN EXAMINATION OF PROBLEMS AND SOLUTIONS RELATED TO THE CHRONIC "REVOLVING DOOR" ALCOHOL ABUSER

John W. Vick
Dorothy Houden

DHSS PLANNING GUIDELINE # 1
TASK ASSIGNMENT # 1.11
LONG TERM SUPPORT
CHRONIC ALCOHOLISM AND OTHER DRUG ABUSE

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Department of Health and Social Services

DECEMBER, 1981

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Task Assignment #1.11
DHSS Planning Guideline #1
Long-Term Support
Chronic Alcoholism and Other Drug Abuse

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Special recognition is extended to Mr. Michael Quirke, Bureau of Alcohol and Other Drug Abuse, for his invaluable contribution in designing the survey instruments and interview protocols coupled with their analytical results that ultimately produced the evidence and subsequent recommendations embodied within the report.

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TABLE OF CONTENTS

Page

I. Introduction and Background 1

II. Alcoholism and Alcohol Abuse: Nature and Consequences. 3

III. Case Study of a Typical Chronic Revolving-Detox-Door Alcohol Abuser (CRA) 6

IV. Analysis, Discussion, and Recommendations

A. Uniform Definition of the Chronic Revolving-Detox-Door Alcohol Abuser 9

B. Fiscal Issues Related to the CRA 14

C. Programming and Services 52

D. Training of Health Care Professionals. 67

V. Conclusion 75

VI. Notes and References. 76

VII. Glossary. 79

VIII. Appendices

A. DHSS Task Assignment #1.11 82

B. CRA Survey Form. 85

C. Interview Schedule 90

D. Panel of Chronic Alcoholism Specialists. 96

E. CRA Screening Instrument 97

F. Medical Disability Criteria. 101

G. The Impact of the Alcohol Problem in Wisconsin (graphs). . .102

H. Draft Detox Screening Items. 107

I. Non-Medical Detox Standards. 110

J. State Medical Society Letter 111

K. Nursing School Letter. 112

L. 51.42 Board Survey 113

M. UW Survey Research Lab Interview Schedule. 116

N. State Dedicated Alcoholic Beverage Taxes 124

I. INTRODUCTION AND BACKGROUND

Federal attention to the needs and rights of "public inebriates"*--persons whose repeated public drunkenness becomes a cause of community concern--was initially expressed in the enactment of the 1970 Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act and its 1974 amendments. Focusing on the public inebriate, this legislation affirmed that public intoxication should not be grounds for criminal prosecution but rather inebriates should be treated to enable them to lead normal lives as productive members of society. Federal goals were translated into state policy in the ensuing years with passage of laws that decriminalized public intoxication. Passage of the Wisconsin Alcoholism and Intoxication Treatment Act (s. 51.45, Wisconsin Statutes), in August of 1974, heralded this state's changed policy towards public inebriates. By June of 1980, 33 states and Puerto Rico, the Virgin Islands and the District of Columbia had adopted similar legislation.

Passage of the Wisconsin decriminalization law gave impetus to the development of an embryonic continuum of care for alcohol abusers, ranging from crisis intervention, detoxification and inpatient treatment at one end to outpatient treatment, halfway houses, and extended care at the other end of the continuum. Many of these services had begun to appear as the state mental hospitals began discharging alcoholic residents in the 1960's. By 1974, Wisconsin treatment providers began to recognize a type of client they refer to as "the chronic revolving-detox-door alcoholic" (CRA),* whose repeated admissions for detoxification services exemplify one extreme in the chronicity of the disease processes inherent to alcoholism. Despite numerous admissions for detoxification and treatment services, the CRA continues to drink and experience the debilitating effects of alcoholism. He or she could be said to typify the failures of traditional treatment methods, where "success" is measured by either total or extended periods of abstinence from alcohol. Obviously, decriminalization of public drunkenness did not create a population of revolving door alcoholics, but rather has resulted in the identification of this population for whom traditional corrective and treatment approaches have proven both costly and ineffective.

While CRA's apparently represent approximately 1% of the state's adult alcohol abusers (2,430 of 258,296) and approximately 8% of 51.42 Board-funded alcoholism clients (2,430 of 30,482), they account for a disproportionately large share of publicly-funded alcoholism service dollars (22%, or $5.8 million of $26 million). Nearly four-fifths of these expenditures for CRA's, moreover, go for detox, which responds to the CRA's acute-care needs, while only one-fifth goes for the CRA's long-term support.

During this period of extreme fiscal austerity and of burgeoning human service caseloads, cost-effectiveness has, of necessity, become an overriding concern in the provision of human services. Because detoxification, inpatient treatment, and many other alcoholism services have proven to be costly and/or ineffective for Wisconsin's CRA's, alternative treatment methodologies need to be developed and alternative funding options explored.

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*NOTE: Please refer to the GLOSSARY on page 79, which defines lesser-known terms used in this report. An asterisk (*) will identify the terms in the text.

Responsive to the human service needs of all Wisconsin residents, the Department of Health and Social Services (DHSS) initiated Planning Guideline #1 which established the Department's long-term support goals for chronically and severely needy adults and for the delivery system that serves them. It identified five target populations: developmentally and physically disabled persons, the frail elderly population, chronically mentally ill persons, and chronic alcoholics and other drug abusers. The Planning Guideline's problem statement emphasized common themes which point to dislocations in this delivery system, and its individual and systemic goals emphasized generic solutions to these problems.

Clearly, however, all five target populations do not encounter identical problems, nor do they all have the same types and levels of needs. Furthermore, these populations are not all perceived in the same manner by the public and professional human service providers. These different perceptions, needs and problems require some unique approaches for those adults who chronically abuse alcohol or who are addicted to other degenerative drugs and for the delivery system that serves them. In recognition of this requirement, a 1980 state plan goal of the Bureau of Alcohol and Other Drug Abuse (BAODA) emphasized the special needs of CRA's in program planning, treatment, and rehabilitation.

Task Assignment #1.11 was issued in the fall of 1980 to examine and explore solutions to some of the most significant problems facing adult chronic revolving-detox-door alcohol abusers (CRA's) and the system that serves and funds them (see Appendix A). The Bureau of Alcohol and Other Drug Abuse of the Division of Community Services was given primary responsibility for carrying out the T. A.'s eight objectives. Eleven staff members from six Divisions within the Department and from the University of Wisconsin-Extension and the Milwaukee Inner City Council on Alcoholism made up the Steering Committee charged to carry out T.A. #1.11. During 1981 the Steering Committee conducted panel discussions, interviews, site visits, mail surveys, and literature reviews in order to arrive at the recommendations contained in this report.

It is the intent of the Steering Committee that this report serve as a catalyst for the DHSS, other state agencies, legislative bodies and the AODA delivery system to join forces in taking steps to develop effective alternative approaches to serve the CRA.

II. ALCOHOLISM AND ALCOHOL ABUSE: NATURE AND CONSEQUENCES

For most people, the stereotyped image of the alcoholic is one of a drunken panhandler nervously awaiting his next dime for that illusive "cup of coffee" or of a skid road derelict's unshaven face observed through the mesh windows of a police van. Most Americans, including sizable segments of the legal and medical professions, look upon the alcoholic as helpless, hopeless and worthy only of pity. Indeed, most Americans believe many of the following myths and prejudices about alcoholism:

- Alcoholism is a self-inflicted illness.
- Alcoholism is hopeless.
- Recovering from alcoholism is a matter of will power.
- Drinking in any amount is dangerous and can lead to alcoholism (i.e. everyone should abstain from drinking alcohol.)
- The poor, sick, indigent, unemployed, lonely, or old person is better off if allowed to continue abusing alcohol.
- Abstinence for an alcoholic is an unrealistic expectation. No one can live that way.
- Alcoholics are simply people who won't accept life's responsibilities.

The fact is that alcoholism* is a progressive illness. A person is not suddenly transformed overnight from a social drinker into an alcoholic; the symptoms of alcoholism appear gradually, rather than all at once. Doctors and researchers recognize several progressive phases in the development of alcoholism.

In the first phase, the drinker begins to drink more often, and more at a time. Perhaps before, he or she drank only on social occasions to "loosen up" and become more relaxed and convivial. Now more occasions become drinking occasions, and the main motivation for drinking is the "high" the alcohol brings, or the easing of problems that seem too painful to face. More and more alcohol is needed to bring the same "high." At this stage the developing alcoholic may begin to experience blackouts.* The day after an occasion of heavy drinking, he/she will be completely unable to recall what he/she said or did during a particular period. It is as though the drinker's memory were a tape recorder, and when he/she tries to replay a certain part of the tape, it is a total blank. Yet people who were with the drinker at the time say that he/she behaved apparently quite normally. He/she did not even seem drunk at the time--he/she talked, walked without staggering, and may even have driven a car, all apparently in full control. Only now he/she cannot remember any of it.

During this first phase of alcoholism, there may be no apparent changes in the alcoholic's personality, even though he or she is drinking increasing amounts of alcohol. At work or school, in family life, the dependent drinker appears to be functioning quite normally. A businessman, for example, may be settled in a routine of steady drinking--a couple of martinis at lunch, two more before dinner, wine during dinner, an after-dinner liqueur, and perhaps a "nightcap" to help him sleep. Then he breaks his leg, is sent to the hospital where he does not receive his regular supply of alcohol, and a couple of days later is astonished to find himself seized by an attack of D.T.'s (delirium tremens).*

In the middle phase of alcoholism, a person drinks not for social reasons but because he has to, in order to maintain physical and emotional equilibrium. Once he takes a drink, he cannot stop, even though he knows that he may make a fool of himself or drink until he passes out. Alcoholics Anonymous members describe the feeling, "One drink is too many, and a hundred is never enough." The blissful "high" that the alcoholic remembers often eludes him, and he drinks more and more in a vain attempt to recapture it. At this stage, the alcoholic's personality begins to change. He may lie about his drinking, or conceal it, or think up elaborate justifications for drinking and fanciful explanations for his behavior. The alcoholic lives more and more in a fantasy world and may be full of plans for future achievements that seem unrealistic to those around him. He wakes up in the morning feeling physically miserable, but a drink makes him feel better. So he makes up alibis about his drinking, rationalizes, and fights attempts to help him stop. He sees these as a threat to take away the only "medicine" he has found that can help him. Denial of the problem is evident at this stage.

During the middle phase of alcoholism, a person can still function reasonably well. But his increasingly unreliable and unpredictable behavior make it more and more difficult to hold a job and may gradually turn the alcoholic's family and friends against him. He may behave aggressively toward people around him, and later be remorseful. He may try to "make it up" to his family and others he has hurt by spending extravagantly on gifts for them. He may promise to give alcohol up, and he may keep his promise for weeks or even months, but then he relapses. Drinking episodes may lead to hospitalization, but often the official diagnosis will be gastritis ("stomach problems") or some other ailment which is more socially acceptable than alcoholism. The doctor may not realize that a patient has a drinking problem, or may try to shield the alcoholic and his family.

In the last stage of alcoholism, the alcoholic is often intoxicated for long periods of time. He will do things to obtain alcohol, like stealing or writing bad checks, that he would not normally have done. If he cannot get a supply of alcoholic beverages, he will drink anything that may be intoxicating like cough medicine, vanilla extract, or rubbing alcohol. He neglects his eating, and related physical problems and illnesses become pronounced. Signs of brain and liver damage may appear. The alcoholic develops persistent tremors or shakes and is unable to do the simplest things like tieing his shoes, or opening a can, without taking a drink first. His/her life, his/her job, his/her family, is falling apart. At this point, abandoning his complicated system of rationalizations about his drinking, the alcoholic may seek help, and a more or less complete recovery (depending on the amount of physical damage which years of heavy drinking have produced) is still possible. Or the alcoholic may "drop out" of normal life entirely. Ultimately he/she may literally drink himself/herself to death. (See Appendix G for Wisconsin alcohol-related death statistics.)

Not all alcoholics go through all the typical stages of alcoholism in precisely the same order, or show all of the characteristic symptoms. There do seem to be two main patterns of alcohol abuse, however, which are characteristic of CRA's: the steady drinker, who drinks perhaps a pint of whiskey or more every day; and the spree or binge drinker, who alternates long periods of sobriety (lasting weeks or months) with drinking binges (lasting days or weeks).

Before this analysis proceeds, it is useful to describe a typical CRA's experience with medical detoxification. The following case study is intended to illustrate the process and some of the strengths and limitations associated with detox.

III. CASE STUDY OF A TYPICAL CHRONIC REVOLVING-DETOX-DOOR ALCOHOL ABUSER (CRA)

Jim Brown, age 43, was brought to the emergency room of the Red County Community Hospital by the County Sheriff's Department. The police found him lying in a doorway near the center of town. Jim was very intoxicated, his clothes were wet and dirty, and he was unable to walk without assistance. Jim had just left a tavern where he had been drinking with his buddies and was on his way home.

The emergency room physician and nurse examined him for physical injuries and then proceeded to do an assessment of his general condition (these assessments typically cost about $85). Jim reported seven consecutive days of drinking white port wine, three fifths each day. His last drink was just prior to the police pick-up. His blood alcohol concentration* was (.23). He had eaten very little in the past seven days. His vital signs were checked revealing his temperature to be normal; his pulse, respirations, and blood pressure were elevated. Jim was oriented as to his identity but disoriented as to place and time. He was generally uncooperative, loud, and used abusive language.

Jim's previous patient record revealed the following medical history: fourteen years of heavy drinking; blackouts;* alcohol withdrawal symptoms including sweating, tremors, elevated vital signs, and anxiety; no seizures; and no delirium tremens. Other medical history revealed high blood pressure, an old history of stomach ulcers, emphysema, and poor nutrition. Psychosocial, family, educational and vocational history revealed the following facts: Jim's father was an alcoholic; his mother and father were divorced when he was ten years old; he has three brothers and two sisters; there was no church affiliation in the family history; the children were placed in foster homes following the divorce; Jim's first drink was at age fifteen, his first time drunk was at age sixteen; he dropped out of school after the ninth grade; he has been arrested many times since age eighteen for theft, disorderly conduct, driving while intoxicated, and public drunkeness; he has worked off-and-on at odd jobs but never held a steady full-time job for more than six months; most of the jobs he held were in restaurants as a dishwasher or cook's helper; he married at age twenty-seven and had two sons from this marriage; his wife divorced him because of his drinking after seven years of marriage; he lives in a downtown hotel and gets funds from general relief; he has consistently had a feeling of hopelessness about his future and suffers from depression when sober; and he has been admitted to alcohol detoxification services four previous times in the past year.

The emergency room staff assessed Jim's condition as incapacitated* by alcohol and admitted him to the hospital's detoxification unit under protective custody (s. 51.45, Wis. Stats.). The treatment plan was to observe and monitor his condition and provide the following treatment: diet as tolerated; urinalysis; multi-vitamin cap daily; Thiamin HCI 100 mg. daily; Maalox 30 ml. every hour as needed for stomach distress; Dalmone 30 mg. for sleeplessness; and Librium* in appropriate dose and frequency as needed to control alcohol withdrawal symptoms. Jim exhibited mild-to-moderate alcohol withdrawal symptoms eight hours after admission. He had visible tremulousness, sweating, anxiety, elevated vital signs and reported nausea and nightmares. He was given Librium 50 mg. every four hours for 12 hours followed by Librium 25 mg. every four hours for another 12 hours.

Thirty-four hours after admission to the hospital Jim was no longer incapacitated by alcohol and was taken off protective custody. An alcoholism counselor met with him within twenty-four hours after admission and reported Jim was not receptive to referral services. Jim left the hospital forty-eight hours after admission against medical advice. The staff felt he could have benefited from a longer stay and more counseling to motivate him to seek help for his problem.

As was mentioned earlier, this was Jim's fifth admission to this detox unit in a year. He left against medical advice on three previous admissions, and on one previous admission he had a regular discharge. Referrals to Alcoholics Anonymous and outpatient treatment services were refused by Jim each time. He left the unit with one thing on his mind: where was he going to get his next drink? The cost for his two days of care was $292 plus $85 for the emergency room examination, all paid for by the county 51.42 Board. All together Jim has cost the system at least $1800 in one year.

This case study is typical of the 2430 or more CRA's in Wisconsin who consume at least $4,465,200 in publicly funded detoxification annually.[5] The majority of these people are male (90%) and have an annual income of about three to four thousand dollars. Half of them are veterans. Twenty percent are retired; fifteen percent are disabled; one-third are employed; the remainder are unemployed.[14]

IV. ANALYSIS, DISCUSSION, AND RECOMMENDATIONS

MAJOR ISSUE A: UNIFORM DEFINITION OF THE CHRONIC REVOLVING-DETOX-DOOR ALCOHOL ABUSER (CRA). THERE DOES NOT EXIST A UNIFORM DEFINITION OF THE CRA, NOR IS THERE AGREEMENT THAT THE CRA IS DISABLED.

SUBISSUE A1: LACK OF A UNIFORM DEFINTION OF THE CRA.

As mentioned earlier, since the implementation of the 1974 Alcoholism and Intoxication Treatment Act (s.51.45, Wis. Stats.), treatment providers have begun to recognize a type of client they refer to as the chronic "revolving-detox-door" alcohol abuser. Though it is estimated that CRA's represent less than 1% of the state's adult alcohol abusing population,[1] they account for a disproportionately large share of 51.42 Board-funded alcoholism prevention, intervention, and treatment dollars (approximately 22% in Calendar Year 1980). Approximately four-fifths of these expenditures for CRA's went for costly emergency medical services which seldom alter CRA's drinking patterns. The resulting concern for efficiency requires that the CRA be identified and means developed to provide more effective services.

The Steering Committee initially approached the task of defining the CRA by reviewing the literature dealing with the chronic alcoholic and by contacting other State Alcohol Offices. These efforts failed to yield satisfactory criteria for identifying the CRA. Most existing criteria, such as those developed for the National Council on Alcoholism by its Criteria Committee, were deemed of limited value to Wisconsin's needs, for two major reasons:

1. Because of the chronic nature of the disease alcoholism, most sets of diagnostic criteria failed to differentiate the alcoholic, for whom traditional treatment resources generally prove fairly effective, from the chronic revolving-detox-door alcoholic.

2. Those diagnostic procedures which could prove useful in distinguishing the non-CRA from the CRA, rely heavily on extremely costly medical assessment methods.

Contact with other states revealed that only Colorado had developed an instrument for classification of alcohol detoxification service clients. The Colorado instrument, used by a Denver mental health clinic, relies heavily on the clinical judgment of the person administering the instrument. Because the Colorado instrument is highly subjective and because no information was available regarding instrument or inter-rater reliability, the instrument was deemed inadequate, in its existing form, to fulfill the intent and purpose of this Committee's task.

The Steering Committee determined, therefore, that an original instrument needed to be designed and pilot-tested. The major purpose of this instrument would be to distinguish the CRA from the non-CRA alcohol abuser. Additionally, the data gathered from application of the instrument would contribute to the development of an individualized plan for more efficient, appropriate, and effective services (e.g. involuntary commitment; follow-up; special counseling; foster care; missions; etc.)

Although funds and resources were insufficient to develop a scientific instrument, near scientific procedures were adhered to in its initial development. Input into the design of the instrument came from the following sources: 144 AODA professionals from around the state (see Appendix B); 27 AODA and medical professionals interviewed in Sawyer, Dane, LaCrosse, Milwaukee, Racine, and Brown counties (see Appendix C); a study of the CRA conducted at St. Catherine's Hospital, Kenosha; and a dozen nationally recognized specialists in the area of chronic alcoholism (see Appendix D).

The draft "Screening Instrument," included in this report as Appendix E, is a result of this input. The 27 short items in this "Instrument" encompass behavioral, associational, and attitudinal dimensions thought by service providers, AODA coordinators, and the panel of specialists to characterize the CRA. As may be seen in Appendix E, the CRA is conceived as occupying an extreme point on a range of dependency on alcohol: "chronic alcohol dependency"--the CRA, "acute alcohol dependency," "problem drinking/no dependency," and "no alcohol problem." More than other alcohol abusers, the CRA is considered to:

- have a history of heavy drinking and drink in public
- experience serious injuries, illnesses, and physical complications
- experience serious psychological problems
- have a history of engaging in illegal acts
- have a history of being victimized in criminal acts
- be unemployed for long periods of time, have less income, and rely on welfare
- have no contact with family or relatives and rely exclusively on other alcoholics for close relationships, and
- be unwilling to acknowledge his or her powerlessness over the dependency on alcohol and to accept help.

Recommendation #1: The Department shall assign to BAODA the task of refining, pilot-testing, field testing, and promotion/marketing of the chronic revolving door alcoholic screening instrument through the various Division of Community Services regional offices for use by county 51.42 agencies. After the reliability of the instrument is determined, and the instrument revised, it should then serve as a local mechanism for the provision of special services; as evidence for disability benefits; and for use in garnering third party payments under special plans. In view of these diverse uses, the administration of the instrument should be determined at the community level.

SUBISSUE A2: IS THE CRA "DISABLED" AND THEREFORE ELIGIBLE FOR DISABILITY BENEFITS AND SERVICES?

From the previous discussion of Subissue A1, it is apparent that the CRA's mental, social, economic, and physical abilities are substantially impaired at the present time, have been so impaired for at least several years, and are likely to remain so impaired or deteriorate over at least the next several years. Yet it is not readily apparent whether or not this individual meets the definition of disability provided by existing laws and rules. The following discussion considers two principal sets of programs. One set, contained in the Social Security Act, offers direct cash benefits and services. The other, contained in the Vocational Rehabilitation Act, offers only services.

1. Programs Offered by the Social Security Act

There are two different disability programs under the Social Security Act which are potential direct funding sources for the chronic alcoholic. They are the Social Security Disability Insurance (SSDI) Program (Title II) and the Supplemental Security Income (SSI) Program (Title XVI). The eligibility criteria for each of these programs are basically the same. To become eligible, the key question is not whether the individual's impairments exist, but rather: 1) whether the person's impairments currently and potentially prohibit gainful employment and 2) whether the impairments are so severe that they have already resulted in either significant damage to certain organs or persistent, extreme disruptions to behavior and perception. More specifically, both programs define disability as "the inability to engage in any substantial gainful activity by reason of medically determinable physical or mental impairment which either can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than twelve months." To be considered disabled, therefore, an individual must pass both economic and medical tests.

a. Economic Test for Disability. Substantial gainful activity is defined to mean the performance of significant duties/work over a reasonable period of time for remuneration or profit or in work of a type generally performed for remuneration or profit. A person is considered to have the ability to engage in substantial gainful activity if he or she earns $300 or more in a month, after using up a grace period of nine months with earnings exceeding $300 for each month. At this point, this person is deemed no longer disabled and is terminated from the SSI program, regardless of the severity of the impairments.

b. Medical Test for Disability. The term "physical or mental impairment" is defined to mean impairment that resulted from anatomical, physiological or psychological abnormalities which are demonstrated by medically acceptable clinical and laboratory diagnostic techniques.

Both SSDI and SSI have specific criteria to evaluate the most frequently encountered impairments of the population to ensure equitable decisions throughout the country. Alcoholism is not considered prima facie evidence of severe impairment, but rather is assessed in two different parameters.

First, the existence and severity of any systemic end-organ damage secondary to the consumption of alcohol are assessed. To evaluate systemic end-organ damage, three basic areas are considered: liver dysfunction, peripheral nerve damage resulting in neuropathy, and Central Nervous System disorder resulting in chronic brain syndrome. Each of these areas has specific medical criteria to be considered (see Appendix F). If an individual has the severity described in the medical criteria, that individual is considered disabled by Social Security.

Second, if there is no systemic end-organ damage or if the degree of damage does not meet the specific criteria, the alcoholic is assessed for non-psychotic functional disorders. These disorders are evaluated according to two criteria, both of which must be met. The first criterion is a resulting persistence of marked restriction of daily activities, constriction of interests, deterioration in personal habits and seriously impaired ability to relate to other people. The second is a marked persistence of one or more of the following clinical signs:

- Demonstrable and persistent structural changes mediated through psycho-physiological channels; or,
- Recurrent and persistent periods of anxiety, with tension, apprehension and interference with concentration and memory; or
- Persistent depressive affect with insomnia, loss of weight and suicidal pre-occupation; or
- Persistent phobic or obsessive ruminations with inappropriate, bizarre or disruptive behavior; or
- Persistent conpulsive ritualistic behavior; or
- Persistent functional disturbance of vision, speech, hearing or use of a limb with demonstrable structural or trophic changes; or
- Persistent, deeply ingrained, maladaptive patterns of behavior manifested by either seclusiveness or autistic thinking or pathologically inappropriate suspiciousness or hostility.

Because the medical criteria, for both systemic end-organ damage and non-psychotic functional disorders, are very stringent, only a very few applicants who are CRA's are found eligible for SSDI and SSI benefits. In fact, in mid-1979, only 24 alcoholics in Wisconsin were receiving SSI benefits on the basis of their having met non-psychotic functional disorder criteria. Although there may have been other CRA's receiving SSDI (or even SSI, for systemic end-organ damage, or for other impairments, or for the combination of other impairments and their alcoholism), they probably were not numerous. (In Table 7 of this report, a very rough estimate of 90 active CRA's receiving SSDI and/or SSI is given.) For a further discussion of issues related to these two programs, see Major Issue B, Subissue B1, on Insufficient Funds.

2. Services Offered Through the Vocational Rehabilitation Act

The Wisconsin Division of Vocational Rehabilitation has developed definitions and guidelines to be utilized in classifying alcoholics. According to a policy statement issued August 28, 1975 (DVR-PI-2, PPM ref. 3115.000), DVR's current position is: "It is anticipated that very few severely disabled alcoholics will be feasible for DVR services," such as evaluation, vocational counseling, placement, work adjustment training, etc.

The view that an individual who is drunk most of the time is not a capable employee is understandable. However, DVR's assistance in combination with a long-term recovery plan tailored to the needs of the CRA and determined by the 51.42 Board, could be very beneficial.

Recommendation #2: The Department shall assign to DVR in conjunction with BAODA, the task of reformulating its policy toward the severely disabled alcoholic so that the CRA may receive vocational rehabilitation services along with a voluntary or involuntary long-term recovery plan. This recovery plan would be determined by the 51 Board.

MAJOR ISSUE AREA B: FISCAL ISSUES RELATED TO THE CRA. 51.42 BOARD EXPENDITURES FOR PROGRAMS FOR THE CRA ARE LARGELY MISSPENT AND INSUFFICIENT.

At first glance, the problems alluded to in this issue -- funds that are not spent appropriately and not enough funds -- may seem contradictory. After all, adding funds to those that are already being misspent is bad public policy. The recommendations regarding this fiscal issue are not contradictory, however. Combined with the recommendations regarding programming (Major Issue C), these fiscal recommendations will provide a proper balance to the acute care and long-term support needs of CRA's. An imbalance presently exists between them, with the bulk of expenditures tilted decidedly to the front end, or acute care side, of the service continuum. This side consists primarily of detoxification services, and secondarily of emergency care (non-detoxification) and inpatient treatment. Merely reallocating these expenditures to other services, which are geared more towards long-term support of CRA's (such as outpatient treatment, extended care, and case management), is not likely to result in a more balanced service system, however. Such a balance is unlikely, largely because large-scale diminution of detoxification expenditures is not feasible in the immediate future and because the long-term support needs of CRA's will likely require more funds than would be gained through reallocation even beyond the immediate future. For these reasons, mere reallocations -- which are difficult enough to accomplish -- are not enough; they must be supplemented with additional funding. Each problem -- inappropriate and insufficient expenditures -- will be addressed in turn.

SUBISSUE B1: 51.42 BOARD EXPENDITURES FOR PROGRAMS FOR THE CRA ARE LARGELY MISSPENT

1. Allocation of Expenditures for the CRA

a. Extent of CRA's Use of Detoxification

The CRA relies heavily on the care provided in public detoxification facilities to cope with frequent periods of drunkenness. This is not surprising, for the very definition of the CRA implies repeated use of detoxification. For the more severe CRA, in fact, periods of sobriety are more the exception than the norm. Informal discussions with 51 Board AODA coordinators and service providers whose clientele consisted primarily of CRA's, however, revealed only minor agreement on who the CRA was. One of the principal objectives of this Task Assignment, therefore, was to develop criteria by which the CRA could be identified and distinguished from other alcoholics or alcohol abusers. This objective was fulfilled, albeit on a preliminary basis, during the course of this Task Assignment, and the findings are reported, above, in Major Issue A, on Definition.

Yet before the framework for a common definition was laid, the Steering Committee had to develop an operating definition of the CRA for purposes of surveying a wide variety of program staff, AODA coordinators, and other knowledgeable persons. The operating definition which was selected for the CRA was an adult who was admitted three or more times during the current or most recent full calendar year to a detoxification facility which was funded by a 51.42 Board. The Division of Community Services Transitional Information System (TIS) indicated that 8,338 unduplicated clients had been admitted to detoxification at least once in 1980. It was impossible to determine for all counties how many times each client had been served in detoxification, but precise figures from a few larger counties and reliable estimates from others indicated that at least 2,430 of the detoxification clients had been admitted three or more times.[1] (See Table 12, in this report, for the estimated number of detoxification clients by number of admissions, for 1980.)

The chronic nature of their alcoholism may be appreciated when the following projections are made. With the average stay in detoxification amounting to nearly 3 days, over 600 CRA's spent an average of more than 34 days (or a full month) in detoxification in a year, and nearly another 500 CRA's probably spent at least two full months in detoxification in a year. Examination of case files in Milwaukee and Dane Counties revealed not uncommon instances of CRA's with more than 30 admissions a year. Several cases were uncovered where more than 45 admissions were logged in a year. Repeated use of detoxification, moreover, had usually been in existence for at least several years, upon examination of selected client histories.

The average cost per client-day in detoxification was found to be $146.[5] Based on an average detoxification espisode of three days, the average annual cost of 51.42 Board-financed detoxification in 1980 was $1,837 for each CRA. The total 51.42 Board-financed detoxification cost for all CRA's in 1980 was $4,465,200.

b. Extent of CRA's Use of Other Alcoholism Services

As noteworthy as the CRA's exorbitant use of detoxification is his or her relatively infrequent use of other alcoholism services (such as halfway houses and inpatient or outpatient treatment) that have been developing over the last two decades. Perhaps the major reason for this differential use is that very few CRA's want to stop drinking. The reader will note one detoxification center director's point of distinction, between the CRA who is truly alcoholic and the CRA who is not alcoholic but drinks to intoxication in order to be accepted for detoxification: the latter does not mind being admitted to an inpatient alcoholism treatment program, whereas the CRA who is alcoholic resists efforts to divert him or her to treatment.

This reliance by the CRA on detoxification to the exclusion or the infrequent use of other alcoholism services can be documented only partially, because hospitals with detoxification programs, 51.42 Boards, and the treatment programs whose services the Boards purchase typically do not gather data on CRA's. The picture of exorbitant reliance on detoxification that emerges from available data is striking, nevertheless. On one hand, nearly $4.5 million was spent by 51.42 Boards in 1980 on publicly financed detoxification of CRA's, defined as persons admitted to detoxification facilities three or more times during the year. Only a little over $1 million, on the other hand, was spent by Boards on extended care facilities, which are typically seen as being geared to the CRA.

Some residents of extended care facilities are probably not alcoholic but rather may be revolving-door clients who mimic alcoholism symptomatology. Most residents of extended care facilities, in fact, are probably former CRA's who are no longer practicing alcoholics but who have become elderly or infirm. Unfortunately, no data were available on the proportion of extended care facility residents who are or were CRA's during the previous twelve months. Estimated residential costs of CRA's who at least had been practicing alcoholics in 1980 and had resided in extended care facilities during that year, were probably less than $500,000, or 50% of aggregate facility costs funded by 51.42 Boards.

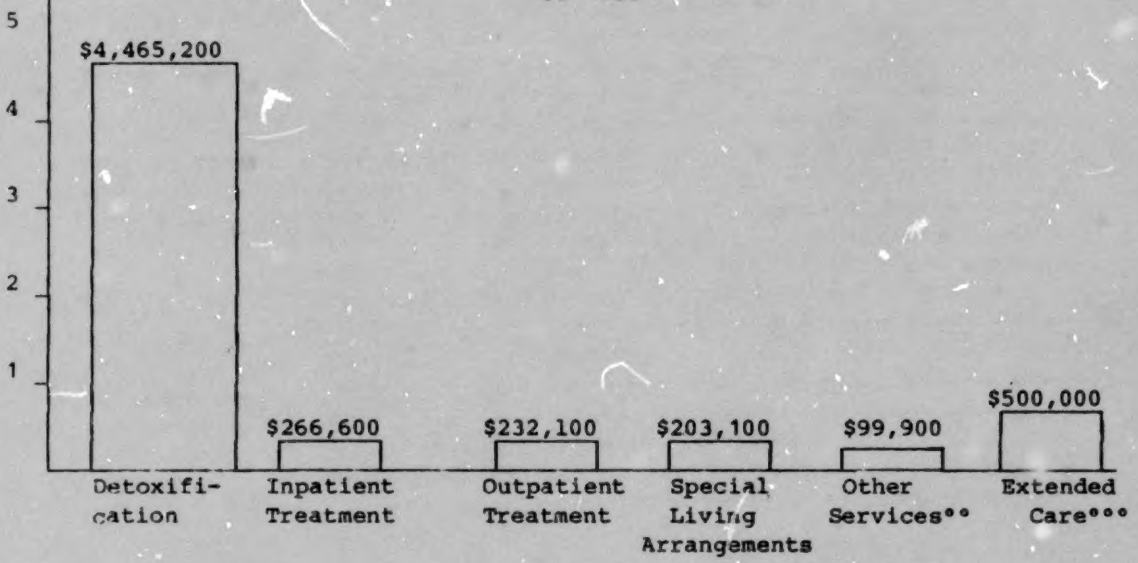
Conversely, the true costs of CRA's in detoxification probably exceeded the $4.5 million figure, stated above, because many hospitals provided detoxification to CRA's as charity cases. In such cases, patients who pay for hospital services bear the resultant higher rates charged by hospitals. In summary, detoxification expenditures for currently or recently practicing CRA's were probably about eight times as great as expenditures for them in extended care facilities in 1980.

In between these services of detoxification and extended care is a wide variety of public and private intervention and treatment services. Included are inpatient and outpatient alcoholism programs, Alcoholics Anonymous, mission houses or centers, halfway houses, emergency care (non-detoxification), protective services, day services, and sheltered employment. It is not known precisely to what extent CRA's use these services, but there are reasons to believe their use is infrequent. First, interviews with detoxification program directors and examination of CRA files in Brown, Milwaukee, Racine, and Sawyer counties revealed that CRA's typically left detoxification against medical advice (AMA) and declined staff advice to receive treatment or some other form of follow-up care. In some counties, moreover, lack of available spaces in these post-detoxification programs made unnecessary such staff advice, a point which will be discussed more fully below. Thus there is considerable support for the argument that CRA's' use of alcoholism services is tilted toward detoxification and away from other services.

Figure 1 provides a rough estimate of the allocation of alcoholism expenditures for CRA's:

Figure 1

Estimated Distribution of 51.42 Board Expenditures for CRA's°
CY 1980



°CRA's represent approximately 8.0% of 30,482 unduplicated 51.42 Board alcohol clients served in 1980. Because the overwhelming majority of AODA coordinators reported infrequent use by CRA's of alcoholism services other than detoxification and extended care, a use rate of 5% was projected for non-detoxification services (except Extended Care).

°°Includes emergency care (non-detoxification), protective services, sheltered employment and day services.

°°°Methodology for calculation given in text.

Although the estimates for the non-detoxification services may be legitimately questioned, they are almost certainly accurate "ballpark" figures. Approximately three out of every four 51.42 Board dollars spent on the CRA in 1980 went to detoxification.

2. Current Impact of CRA Expenditures on Various AODA Service Expenditures

a. Impact on Detoxification

Because 51.42 Boards are constrained to provide limitless detoxification services within finite budgets (s.51.45(9)(c), Wis. Stats.), their ability to fund a growing alcohol clientele is compromised by CRA's' exorbitant reliance on detoxification. CRA's represented 29.1% of unduplicated detoxification clients (or 2,430 of 8,338) in 1980, yet, because they heavily relied on detoxification, they accounted for 78.4% of all 51.42 Board-funded detoxification costs (or $4,465,200 of $5,694,600). Another way to express this disproportionate impact on detoxification expenditures is that the average CRA cost approximately nine times as much as the average non-CRA in detoxification in 1980 ($1,837 compared to $205).

Programmatically, detoxification staff interviews held by the Steering Committee uncovered a high degree of staff familiarity with individual CRA's, to the point where, once removed from life-threatening crises, the CRA's behaviors and needs were typically anticipated by staff. In approximately half their detoxification episodes, CRA's passed the crisis stage after 1-3 hours of observation.

b. Impact on Other Alcoholism Services

Whereas CRA's constituted slightly more than a quarter of all 51.42 Board-funded detoxification clients, they represented only 8.0% of 30,482 unduplicated alcoholism clients served by 51.42 Boards in 1980. Yet, their estimated use of these services ($5,766,900), accounted for 22.1% of the total 1980 51.42 Board-funded alcoholism expenditures ($26,039,400), or nearly three times the proportion one would expect from CRA's numerical representation. The CRAs' use of detoxification, alone, accounted for 17.1% of all alcoholism expenditures (including prevention, intervention, treatment, ancillary services, and long-term support).

3. Future Impact of CRA Expenditures on Various AODA Service Expenditures

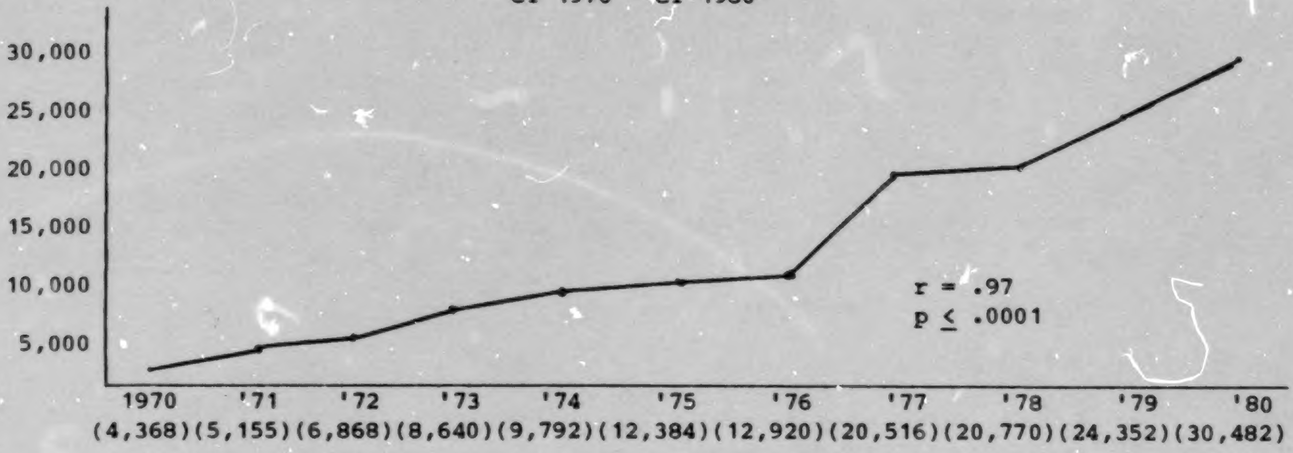
Predictions on the future numbers of CRA's are almost purely speculative, because the factors that swell or reduce their ranks defy careful analysis. One of these factors, it has been found, is the characteristic migration of many CRA's to and from metropolitan areas adjacent to Wisconsin. A second factor is the condition of the state's economy. It is clear from reports from hospitals and other sources that the 2,430 CRA's estimated in this report are only the "visible" alcoholics who frequent public detoxification facilities. There may be as many who are "invisible" to the public system but who appear for detoxification of one kind or another three or more times a year in hospitals, clinics, nursing homes, or in their own homes or relatives' homes. A prolonged recession, a restriction in third-party eligibility rules, or a related change may force these alcoholics onto the public treatment system or deprive them of a funding source other than Minimum Tentative Allocations (MTA's), the primary source of 51.42 Board funding (see Figure 3 in this report). A third factor that may affect the future numbers of CRA's concerns reported increased numbers of youths who are consuming alcoholic beverages in amounts and at frequencies that harbinger alcoholic careers.[15] A fourth factor is the reduction or elimination of information and referral services, as authorized by the 1981-83 Biennial Budget Act.

Interviews of detoxification staff, other alcoholism service providers, and AODA coordinators in Brown, Milwaukee, Racine, and Sawyer Counties indicated that, on the whole, the recidivist problem is neither decreasing nor increasing, but seems to have stabilized. At least for the next five years, then, the number of CRA's is expected to remain basically the same, barring significant programmatic or economic changes.

Regardless of their projected numerical stability, continuation of the current service system for CRA's will probably result in denial of alcoholism services to increasing numbers of non-CRA needy persons, for two reasons. First, as inflation persists, CRA's will probably consume growing proportions of 51.42 boards' AODA budgets, because counties will be just as constrained then as they are today to detoxify CRA's. Second, during the next five years, the number of non-CRA's seeking alcoholism services (including detoxification) is expected to continue its upward spiral of recent years, as reflected in Figure 2.

Figure 2

Unduplicated Clients Served in 51.42 Board-Funded Alcohol Abuse Programs
CY 1970 - CY 1980[5]



In effect, even though the numbers of CRA's are not expected to increase in the immediate future, more clients are expected to compete for scarcer alcoholism resources. Failure to program effectively for CRA's, therefore, will have serious repercussions for other persons needing alcoholism services in the immediate future.

4. Nature and Cost of Alcoholism Services for CRA's

This section describes some of the costs and key programmatic aspects of six alcoholism services (detoxification, inpatient and outpatient treatment, special living arrangements, extended care, and case management). The relative effectiveness of these services is discussed more fully in Major Issue C, on Programming.

a. Detoxification

Medical detoxification centers are 24-hour services typically located in a hospital or other health care facility. They serve the purpose of providing a safe setting for the client while the alcohol is being eliminated from his or her body, as well as monitoring and treating any side effects (tremors, seizures, convulsions, hallucinations, etc.) which might occur during the sobering-up process. These centers have either a full-time physician or a consulting physician, as well as registered nurses and counselors. They typically have fewer than 10 beds (though some have as many as 20) and are not designed to handle medical emergencies, such as traumatic injuries or multiple chronic illnesses (emphysema, liver cirrhosis, hypertension), which may complicate the sobering-up process. They also prescribe and supervise the administration of medications.

The revolving-door client served by these centers typically stays about two-to-three days. Usually 99% refuse to follow through on referral advice.[9] The cost for these services ranges between $52 and $267 per client-day.[8] The average costs are $146 per client-day for medical detoxification. In Wisconsin, between 40% and 60% of all clients who are admitted to a center like this will need the medical treatment.

On the other hand, social setting or non-medical detoxification may be utilized in the 40%-60% of the cases where the client has been medically examined and determined not to need full or limited medical attention (medications, nursing care, constant watching, restraints, etc.). The non-medical services range from $18 to $120 per client-day and average $63 per client-day.[9] The services are usually provided in a receptive and home-like atmosphere. Staff have not had medical training but have been trained to make judgments about a client's physical condition. Medical back-up services are usually available within minutes, if needed. These programs are generally drug-free (for example, they would sooner use ice bags than aspirins). Exceptions occur when a client is admitted with a prescribed drug.

Typical cost for detoxification, in general, is $146 per client-day. The total 1980 costs for detoxification were $5,694,854, or 22% of all 51.42 Board-funded alcoholism costs.

Table 1

Recent Costs Per Detoxification Client

	1978	1979	1980
Clients receiving detoxification services	7274	7320	8338
Cost per client served (2-3 days of care)	$582	$677	$683

All indications are that utilization of detox services will continue at or exceed 1980 levels, allowing little room for inflation.

Detoxification centers or programs are designed seldom to help a client begin recovery from alcoholism, but rather to remove a client from a life-threatening situation as quickly and as safely as possible; hence, their appellation, Emergency Care II.

Currently, publicly funded non-medical detoxification beds represent 18% of the total detox beds available in the state.[11] In Milwaukee County, they account for 28%. Theoretically, however, if 40-60% of all admissions to a detoxification facility can be handled non-medically, approximately 40-60% of beds should be non-medical.

With a medical-to-non-medical cost differential of approximately $83 per client-day, it is possible that conversion of existing medical beds to non-medical status could generate substantial detoxification cost savings, with no reduced level of effectiveness. Although the average CRA's non-medical detoxification episode might advisably be longer than the current two-to-three day average for medical detoxification, the nature of the non-medical detoxification might reduce the frequency of the CRA's admissions. This possibility is raised in Major Issue C, on Programming.

Another related detoxification fiscal problem is the variability of detoxification treatment rates per client-day. One county, for example, may incur a public cost of $132 per day to detoxify a typical client, while another county, due to various circumstances, may incur $264 of detoxification costs per client-day for the same level of care. As noted earlier, the typical cost for Wisconsin medical detoxification was $146 per client-day during 1980, but the range spanned $215, from $52 to $267 per client-day. From information gathered from interviews with county detoxification facilities, the following variations in detoxification rates were uncovered:

Table 2

Range of Detoxification Costs
1980

Type of Detox	Costs
Medical Detox	$52-$267 per client-day
Non-Medical Detox	$10-$163 per client-day
Medical Screening/Examination	$20-$85 per detox episode

b. Inpatient Treatment

This is a 24-hour institutional service provided in a specialized hospital alcohol unit or free-standing facility under medical supervision, lasting, on the average, approximately 18 days. Clients reside on the ward and receive a structured daily program of medical supervision, therapy, and education. The typical cost of this service is $96 per client-day. The total 1980 costs were $5,329,408, or 20% of all 51.42 Board-funded alcoholism costs.

Table 3

Recent Costs per Inpatient Treatment Client

	1978	1979	1980
Clients treated in inpatient services	2920	2790	2974
Cost per client served (18 days of care)	$1414	$1713	$1792

This category of alcoholism services is the only one which is experiencing stable or declining client numbers. There is some possibility, therefore, of reallocating funds from this service to other programs for the CRA or to outpatient treatment in order to offset that category's inflationary factors.

c. Outpatient Treatment

This service consists of one-to-one, group or family counseling, utilizing various psychotherapeutic techniques, designed to motivate the alcohol abusing client or family to accept their alcohol problem and work through any associated job, family, or sexual problems. The counseling is supposed to occur once or twice a week for a typical period of about six months. The typical cost for an hour of this service is $23. Total 1980 costs were $4,641,232, or 18% of all 51.42 Board-funded alcoholism costs.

Table 4

Recent Costs per Outpatient Treatment Client

	1978	1979	1980
Clients treated in outpatient services	13,394	16,771	21,688
Cost per client served (9-12 sessions)	$259	$229	$214

d. Special Living Arrangements

These are typically halfway houses which provide a 24-hour non-medical residence and enable the resident who is leaving inpatient care to make the transition back to independent living. A family-like atmosphere is provided with counseling, attendance at AA, and participation in a day-time activity (job, school, etc.). The typical stay is three-to-four months and costs average about $21 per resident-day. The total 1980 costs were $4,062,114, or approximately 16% of all 51.42 Board-funded alcoholism costs.

Table 5

Recent Costs per SLA Resident

	1978	1979	1980
Residents served in halfway houses	2356	2257	2817
Cost per resident served (approximately 2-3 months)	$1314	$1642	$1442

e. Extended Care

This category of 24-hour residential care is geared towards the more chronic and possibly the revolving door alcohol abuser. It is generally a foster home, group home, or a nursing home which provides shelter, meals, counseling, recreation and custodial care, as needed. Clients are typically less able to care for themselves and either need a longer-term program to return them to independent living or live out their last years in these residences. The typical length of stay in a program like this might be six months to two years. Those residents staying for longer periods of time are usually supported by various public services, which rely only in part on 51.42 Board funding. The typical cost per resident-day for this type of program is $18. The total 1980 costs were $1,002,416, or approximately 4% of all 51.42 Board-funded alcoholism costs.

Table 6

Recent Costs per Extended Care Resident

	1978	1979	1980
Residents served in extended care services	351	395	496
Cost per resident served (approximately 6 months of care)	$2298	$2745	$2021

f. Case Management

While most counties responded that they had a case management system for all their alcohol abusing clients, closer examination revealed that only three counties -- Dane (for North Bay Lodge residents only), Racine, and Sheboygan -- were funding special case managers for their CRA's. It was also found that there was no formal follow-up or case management after clients left detoxification. Some hospital detoxification programs, in fact, apparently discharged CRA's without even having them see a 51.42 Board counselor. Effective case management requires assessment, treatment plan development, referral to services, follow-up and review. It is the last two services in which most counties seem deficient. Follow-up and review are not office-specific tasks. They require often painstaking effort, as many

CRA's live reclusively or transiently. When it is understood that most CRA's are unwilling to accept further care after detoxification and that most leave AMA, the reluctance of most counties to follow up and review can be better appreciated, though not condoned.

5. Recommendations Regarding Subissue B1 (Misspent Funds)

Five facts emerge from the preceding discussion of distribution of program expenditures for CRA's. First, the current public system of alcoholism services is tilted decidedly towards acute care (primarily detoxification) and away from long-term support services, despite the CRA's history of dependency on alcohol, and this tilt is perceived by the overwhleming majority of providers and AODA coordinators. Second, for most of its clients detoxification has proven to be effective in preventing deaths and extreme, life-threatening complications from alcohol withdrawal symptoms. Third, in its present form and without the use of other services, detoxification has proven to be ineffective in guiding CRA's toward recovery from their dependence on alcohol. Fourth, non-medical detoxification services are not as prevalent as would be indicated by a reasonable estimate that nearly half of all admissions to detoxification facilities could be handled non-medically. Fifth, both the expected growth in clientele for alcoholism services, generally, and the expected decline in purchasing power of 51.42 Board alcoholism dollars mean that CRA's projected use of detoxification will make it more difficult for services to reach non-CRA clients, and this prospect frustrates providers.

Before recommendations are offered, some observations on the barriers to reallocation of alcoholism expenditures are appropriate. In this Subissue, it was estimated that nearly three out of every four 51.42 Board dollars spent on CRA's went to detoxification, which is ineffective by itself in reversing or decelerating most CRA's dependence on alcohol. Yet reallocation of current alcoholism expenditures for CRA's towards more effective programs or at least less costly forms of detoxification has its limits. In the first place, there is already tremendous pressure to service increasing numbers of clients in these programs, as was shown in Tables 4-6. A recent survey showed virtually no slack in these programs.[12] Diversion of CRA clients from detoxification would entail expansion of capacity of these programs and, in the cases of SLA's and some extended care facilities, renovation or construction of new buildings. In the second place, several barriers are likely to retard the conversion of medical detoxification beds to non-medical beds. Among these are the absence of Medicaid reimbursement for non-medical detoxification, the resistance expected from some physicians, nurses, and AODA paraprofessionals, and the training required of all three groups in the provision of non-medical detoxification. In the third place, unless detoxification is no longer made a required service or unless counties are authorized to deny detoxification to individuals who have used it in excess of a specificed number of episodes, it is likely that CRA's and counties will continue to resort to detoxification despite efforts to make other, more promising programs more attractive. For CRA's, detoxification is a crucial component of their dependence on alcohol, that is, detoxification enables them to continue drinking while it removes, reduces, or postpones life-threatening conditions. For counties, detoxification keeps CRA's off the streets, away from socially undesirable activities, such as panhandling, and out of jails and lock-ups. Failure to provide detoxification when it is medically indicated, under current statutes, invites lawsuits against counties from CRA's, their friends, and advocates. In summary, there is a set of strong incentives towards maintaining detoxification for CRA's. Removing or countering these incentives is one focus of Major Issue C, on Programming.

The following recommendations do not address these barriers, but rather offer some general directions to follow. These directions will be elaborated in Major Issue C, on Programming.

Recommendation 3: *The Department should take steps to discourage CRA's and some 51.42 Boards' reliance on detoxification as the predominant alcoholism service for CRA's. (These steps are delineated in the recommendations regarding Major Issue C, on Programming.)*

Recommendation 4: *The Department should promote the conversion of medical detoxification beds to non-medical beds, based on an analysis of need and availability and feasibility of development of alternative resources. (This process is further described in the recommendations regarding Major Issue C, on Programming.)*

Recommendation 5: *The Department should require 51.42 Boards to set aside a portion of their alcoholism budgets to develop and provide, as part of intervention services, case management for CRA's during and following detoxification. (This process is further described in the recommendations regarding Major Issue C, on Programming.)*

Recommendation 6: *The Department should promote the establishment of a uniform per day rate for both medical and non-medical detoxification services.*

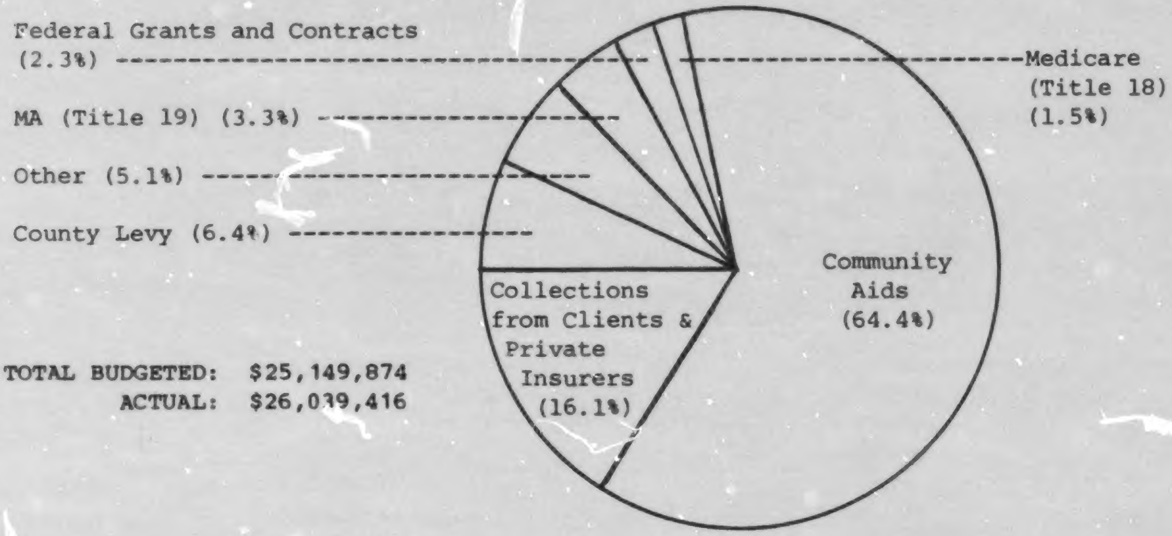
SUBISSUE B2: 51.42 BOARD EXPENDITURES FOR THE CRA ARE INSUFFICIENT TO PROVIDE EFFECTIVE PROGRAMMING -- OBSTACLES TO AND OPPORTUNITIES FOR INCREASING THIRD PARTY PAYMENTS

This section considers a key element in a strategy to develop or expand alternative, more effective programming for CRA's: additional funding. A survey of 51.42 Board AODA coordinators in the summer of 1981 (88% response rate) indicated lack of sufficient funding as a major problem in attempting to program effectively for the CRA.[1] This concern was echoed by nearly all the detoxification directors and other service providers who were interviewed in Brown, Milwaukee, Racine, and Sawyer Counties.[2]

Figure 3 displays recent sources of budgeted funds for alcoholism services which were either provided or purchased by 51.42 Boards.

FIGURE 3

Sources of County (51.42 Board) Budgeted Alcoholism Expenditures
CY 1980



TOTAL BUDGETED: $25,149,874
ACTUAL: $26,039,416

Nearly two-thirds of all alcoholism expenditures budgeted by 51.42 Boards were funded from Community Aids. The next most prominent source of funds was collections from clients and private health insurers.

Assuming the improbability of deriving additional funds from Community Aids, counties, CRA's, Medicare, or the recently enacted federal Mental Health/AODA Block Grant, several other potentially more promising funding sources are examined:

1) SSI and SSDI
2) Medical Assistance
3) Veterans Administration
4) Private Health Insurance
5) Sales Tax

1. SSI and SSDI

a. Background and Findings

1) Extent of Participation in Programs. As was discussed earlier under Major Issue A of this report, CRA's may be considered disabled and therefore eligible for disability benefits from the Social Security Disability Insurance (SSDI) and the Supplemental Security Income (SSI) programs under Titles II and XVI, respectively, of the Social Security Act. Out of an estimated 1980 statewide population of 2,430 active CRA's, however, fewer than 10 were estimated to be eligible for disability benefits from SSI on the basis of their addiction. Possibly an additional 80 active CRA's were eligible for SSI and/or SSDI for some other reason(s). Thus, less than 4% of active CRA's (90 out of 2,430) were eligible for SSI/SSDI. Finally, another 20 recently but no longer active CRA's were estimated to be eligible on the basis of their addiction. The reasons for this low representation will be analyzed more fully, below.

The only eligibility figures that were actually available from the Social Security Administration (SSA) covered the SSI (Title XVI) population. These figures, moreover, included only those alcoholics who were found disabled when evaluated under a particular category of disability. This category, called "non-psychotic functional disorders," was discussed above in Major Issue A of this report. It includes a subcategory of persons who are further classified as Drug Addicts and Alcoholics (DA and A). It is this particular subcategory which comprised the eligible population of CRA's whose addiction formed the basis of their eligibility.

As of June 1979, there were 4,599 people nationally who were receiving SSI benefits under the functional disorder criteria and were further classified as DA and A. These represented 0.2% of all SSI beneficiaries who were eligible on the basis of some disability. As of the same date, however, only 24 Wisconsin citizens were receiving SSI benefits as DA and A. These represented .08% of the approximately 30,000 persons in Wisconsin who were eligible for SSI benefits on the basis of some disability. Although Wisconsin's percentage was significantly lower than the national average, it was consistent with the Region in which Wisconsin is located. In Region V of HHS, which consists of Wisconsin and five nearby states, a total of 197 persons were receiving SSI benefits as DA and A in June of 1979. These represented .07% of the total Regional population receiving SSI benefits on the basis of some disability. The difference between the Regional and the national DA and A representations of .07% and .2%, respectively, is significant at the .001 level, using the proportions difference test. There are no more recent statistical reports available, but, if anything, both the absolute number of SSI beneficiaries classified as DA and A and the percentage of these individuals compared to the total population of disabled SSI beneficiaries have probably declined. The reasons for these suspected declines will be presented below, under "Prospects for Future Eligibility."

In addition to DA and A, there are other categories of SSI eligibility which may have included CRA's. One such category may have included persons who also had other impairments (such as systemic end-organ damage) and were receiving SSI benefits either for these impairments or for the combination of these impairments and their alcoholism. There probably are as many as 1,000 persons who are currently recieving SSI benefits because they have sustained systemic end-organ damage from years of excessive drinking. It is not known, however, whether they still are drinking to intoxication. Another such category may have included, CRA's who had been found eligible because they were elderly and/or blind. No CRA's in any of these categories are included in the figure of 24 Wisconsin SSI beneficiaries who were classified as DA and A in 1979.

Additionally, these figures do not include SSDI (Title II) beneficiaries who may have been CRA's. Unfortunately, there is no data base that has this kind of information, according to staff of the Disability Assurance Branch of the SSA's Region V Office, in Chicago. There is little reason to believe that more than several Wisconsin CRA's are receiving SSDI benefits on the basis of a determination of a non-psychotic functional disorder manifested by alcoholism.

Finally, there may be as many as 9,000 non-CRA alcohol abusers in Wisconsin who are receiving SSDI and/or SSI benefits but who are eligible for these programs for some reason other than primary alcoholism. These reasons may include some other disability, blindness, or old age. Probably very few of these abusers are CRA's. For further information on the number of beneficiaries who are estimated to be alcohol abusers or CRA's, see Table 7.

2) Special Conditions for Participation under SSI. In addition to the different bases of disability determination within SSDI and SSI, there is an important distinction between these programs. It occurs at the end of the evaluation process for disability claims

when an applicant is found disabled for drug addition or alcoholism. Applicants whose sole or primary impairment is drug addiction or alcoholism and who are found disabled for SSDI (Title II) claims are processed in standard fashion with other SSDI allowances. In contrast, some SSI (Title XVI) applicants who are found disabled for alcoholism or drug addiction are further evaluated once their claims have been processed and benefits generated. This further evaluation is summarized, as follows:

a) Whenever an application for SSI (Title XVI) benefits has been allowed and the applicant's primary or sole impairment is due to drug addition or alcoholism, a decision must be made by the State Agency (in Wisconsin, the Bureau of Social Security Disability Insurance (BSSDI) of the Department's Division of Economic Assistance) to determine whether or not the applicant's impairment(s) would still be severe enough to qualify him or her for benefits after the alcoholism or addiction is stopped.

b) A determination that the impairment is not likely to remain severe enough in the absence of alcoholism or drug addiction is grounds for classifying the applicant as DA and A, or primary alcoholism or drug addiction. This determination is usually made when an applicant is found disabled based on the criteria for the non-psychotic functional disorders; it is not made when an applicant has systemic end-organ damage.

c) In these cases and as a condition of eligibility for SSI payments, an applicant must undergo treatment for drug addiction or alcoholism, if such treatment is determined to be appropriate in the particular case and is available at an institution or facility approved by the federal Social Security Administration.

d) The applicant must also demonstrate compliance with the terms, conditions and requirements of such treatment in order to be eligible for SSI payments.

e) Additionally, the law requires payments to be made to a representative payee, rather than directly to the beneficiary. (Many claimants allowed for psychiatric or psychological impairments also have representative payees.)

f) Finally, every case in which chronic alcoholism or drug addiction is material to the finding of disability is subject to a medical re-examination within twelve months to determine if the impairment still meets the criteria for disability.

The policy implications of these differences between DA and A claims and other claims will be analyzed, below, in the "Analysis" segment of this subissue, on Insufficient Funding.

lower than the national average, it was consistent with the Region in which Wisconsin is located. In Region V of HHS, which consists of Wisconsin and five nearby states, a total of 197 persons were receiving SSI benefits as DA and A in June of 1979. These represented .07% of the total Regional population receiving SSI benefits on the basis of some disability. The difference between the Regional and the national DA and A representations of .07% and .2%, respectively, is significant at the .001 level, using the proportions difference test. There are no more recent statistical reports available, but, if anything, both the absolute number of SSI beneficiaries classified as DA and A and the percentage of these individuals compared to the total population of disabled SSI beneficiaries have probably declined. The reasons for these suspected declines will be presented below, under "Prospects for Future Eligibility."

In addition to DA and A, there are other categories of SSI eligibility which may have included CRA's. One such category may have included persons who also had other impairments (such as systemic end-organ damage) and were receiving SSI benefits either for these impairments or for the combination of these impairments and their alcoholism. There probably are as many as 1,000 persons who are currently recieving SSI benefits because they have sustained systemic end-organ damage from years of excessive drinking. It is not known, however, whether they still are drinking to intoxication. Another such category may have included, CRA's who had been found eligible because they were elderly and/or blind. No CRA's in any of these categories are included in the figure of 24 Wisconsin SSI beneficiaries who were classified as DA and A in 1979.

Additionally, these figures do not include SSDI (Title II) beneficiaries who may have been CRA's. Unfortunately, there is no data base that has this kind of information, according to staff of the Disability Assurance Branch of the SSA's Region V Office, in Chicago. There is little reason to believe that more than several Wisconsin CRA's are receiving SSDI benefits on the basis of a determination of a non-psychotic functional disorder manifested by alcoholism.

Finally, there may be as many as 9,000 non-CRA alcohol abusers in Wisconsin who are receiving SSDI and/or SSI benefits but who are eligible for these programs for some reason other than primary alcoholism. These reasons may include some other disability, blindness, or old age. Probably very few of these abusers are CRA's. For further information on the number of beneficiaries who are estimated to be alcohol abusers or CRA's, see Table 7.

2) Special Conditions for Participation under SSI. In addition to the different bases of disability determination within SSDI and SSI, there is an important distinction between these programs. It occurs at the end of the evaluation process for disability claims

when an applicant is found disabled for drug addition or alcoholism. Applicants whose sole or primary impairment is drug addiction or alcoholism and who are found disabled for SSDI (Title II) claims are processed in standard fashion with other SSDI allowances. In contrast, some SSI (Title XVI) applicants who are found disabled for alcoholism or drug addiction are further evaluated once their claims have been processed and benefits generated. This further evaluation is summarized, as follows:

a) Whenever an application for SSI (Title XVI) benefits has been allowed and the applicant's primary or sole impairment is due to drug addition or alcoholism, a decision must be made by the State Agency (in Wisconsin, the Bureau of Social Security Disability Insurance (BSSDI) of the Department's Division of Economic Assistance) to determine whether or not the applicant's impairment(s) would still be severe enough to qualify him or her for benefits after the alcoholism or addiction is stopped.

b) A determination that the impairment is not likely to remain severe enough in the absence of alcoholism or drug addiction is grounds for classifying the applicant as DA and A, or primary alcoholism or drug addiction. This determination is usually made when an applicant is found disabled based on the criteria for the non-psychotic functional disorders; it is not made when an applicant has systemic end-organ damage.

c) In these cases and as a condition of eligibility for SSI payments, an applicant must undergo treatment for drug addiction or alcoholism, if such treatment is determined to be appropriate in the particular case and is available at an institution or facility approved by the federal Social Security Administration.

d) The applicant must also demonstrate compliance with the terms, conditions and requirements of such treatment in order to be eligible for SSI payments.

e) Additionally, the law requires payments to be made to a representative payee, rather than directly to the beneficiary. (Many claimants allowed for psychiatric or psychological impairments also have representative payees.)

f) Finally, every case in which chronic alcoholism or drug addiction is material to the finding of disability is subject to a medical re-examination within twelve months to determine if the impairment still meets the criteria for disability.

The policy implications of these differences between DA and A claims and other claims will be analyzed, below, in the "Analysis" segment of this subissue, on Insufficient Funding.

3) Appeals of Intial Denials of Disability. In the Final Report and Recommendations of Task Assignment 1.8 (Issues in the SSI Supplement Program) (p.9) there appeared an allegation that there was a relatively high reversal rate at the Administrative Law Judge level in the Milwaukee area for denied applicants whose only impairment was chronic alcoholism or drug addiction. The Administrative Law Judge appeal level is the second stage of appeal for applicants who have been denied either SSDI or SSI disability benefits and it is the first level of appeal which is outside of SSA's jurisdiction. The Administrative Law Judges historically have had more lattitude to exercise their judgment on a case-by-case basis than the State Agencies which initially process the claims. It seemed entirely possible, therefore, that this level of appeal might have a high reversal rate for this population in Wisconsin. Legal Action in Milwaukee and the Legal Aid Society in Milwaukee were contacted to determine if their attorneys specializing in Social Security Disability claims had any knowledge about the number of citizens they represented at the Administrative Law Judge level who were found eligible for either SSDI or SSI benefits and whose primary impairment was either drug addiction or alcoholism. Surprisingly, only one of the attorneys who was contacted recalled any Administrative Law Judge reversals of initial denials of disability applications in which the applicants had either drug addiction or alcoholism. In the two reversals that were recalled, however, the applicants also had other impairments and the other impairments were the reasons why the Administrative Law Judge reversed the State Agency decision. Thus there does not appear to be evidence supporting the assumption that Administrative Law Judges in Region V reverse State Agency denials of DA and A claims.

4) Prospects for Future Eligibility. At this time it does not appear that more than a very few Wisconsin citizens are receiving payments under either the SSDI or the SSI programs because they have been determined to be alcoholics. What are the future possibilities regarding this type of payment? Projections are difficult to make, but certain trends, policy clarifications, and legislative actions point to the prospect that applicants for Social Security Disability benefits who are CRA's are probably less likely to be found eligible for such benefits today than in the past, and will probably more likely be denied these benefits in the near future. The primary reason for this prospect is that policy clarifications from the SSA point to the advent of a more stringent interpretation of evaluation criteria for all psychiatric impairments, including the non-psychotic functional disorders. The specific areas affected by these policy clarifications deal with the assessment of the persistence of marked restriction of daily activities, constriction of interests, deterioration in personal habits, and seriously impaired ability to relate to other people. The immediate effect of these policy clarifications is that much more documentation than in the recent past will be required to construct the evidence for severity of

impairment. Experience has found that the more documentation that is secured in these areas, the less likely it is that the applicants will be found to meet all aspects of the criteria.

Superimposed on the policy changes regarding the assessment of severity are recent federal legislation and a Reagan Administration decision which, taken together, augur a high number of terminations of existing disability benefits for alcoholism. The 1980 Social Security Disability Amendments Act (PL 96-265) contained a provision requiring reviews every three years of basically all claims for people receiving either SSDI or SSI disability benefits. This provision was scheduled to become effective in January of 1982. Because the Reagan Administration was concerned about what it perceived as both the high number of people receiving disability benefits and the likelihood that many of those recipients were not truly entitled to the benefits, however, it backdated the review to July of 1981. The BSSDI is currently receiving a large number of claims on individuals who have been found disabled and have been receiving disability benefits for several years. The termination rate for these claims is, thus far, approximately 50%. This high rate is probably a result of selection of cases which implied a likelihood of termination. The SSA is currently estimating a 25%-30% termination rate for remaining claims, still a large number for those persons who were initially found disabled because they had non-psychotic functional disorders, based on the more stringent interpretation of the eligibility criteria. Because this group contains individuals classified as DA and A and because some of these alcoholics and drug addicts are actually receiving treatment under SSI, it appears likely that the terminations may narrow their options for recovery.

b. Analysis

Clearly, the purposes of the special DA and A conditions for participation in SSI, discussed above, are to encourage treatment of the alcoholic and drug addict and to reduce their opportunities to use SSI payments to continue their addiction. Yet, because these primary alcoholism or drug addiction criteria are employed in eligibility determinations only after the exhaustion of all other possible criteria (such as old age, blindness, systemic end-organ damage and other impairments), persons who may be CRA's may participate in SSI with their addiction programmatically unacknowledged and untreated. In fact, CRA's who are eligible for SSI and/or SSDI for some reason other than their addiction may use their direct payments to continue their addiction. Perhaps this anomaly can best be shown through the following table:

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Table 7

Differential SSI/SSDI Program Conditions for Alcoholics and Other Drug Abusers (AODA's)[a]

Non-Fiscal Criteria on Which SSI/SSDI Eligibility is Established	Treatment and Rehabilitation for AODA's	Fiscal Discretion Available to AODA's	Number of Beneficiaries		
			All	Alcohol Abusers Only[g]	CRA's Only[i]
1. Primary alcoholism or drug abuse					
a. DA and A (SSI)	required	not free to spend; payment goes to representative payee	24[b]	24[h]	2[j]
b. Sole or primary impairment (SSDI)	not required	free to spend	4[c]	4[h]	4[j]
2. Other criteria					
a. Systemic end-organ damage (SSI)	not required	free to spend	1,000[d]	250[d]	2[j]
b. Other disability (SSDI, SSI)	not required	free to spend	75,200[e]	6,159	58
c. Blindness (SSDI, SSI)	not required	free to spend	1,000[f]	82	-
d. Old age (SSI)	not required	free to spend	31,500[f]	2,580	24
			108,728	9,099	90

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[a] This table refers to persons whose alcoholism or drug addiction may or may not be apparent to disability determination specialists. Even if it is so perceived, the alcoholism or drug addiction may be considered secondary to other criteria or "not necessary to note."

[b] Based on June 1979 data provided by the Disability Assurance Branch (DAB), SSA Region V.

[c] Estimate based on conversations with Madison Social Security Office, in January of 1981, and BSSDI staff, in December of 1981.

[d] Estimate based on conversations with BSSDI staff, in December of 1981.

[e] Estimate based on 1978 data for unduplicated working age recipients, provided by the Rehabilitation Facilities of Wisconsin. More recent data for duplicated working age recipients indicate 84,127 beneficiaries consisting of 47,819 SSDI beneficiaries (June 1980) and 36,308 SSI beneficiaries (July 1981). Source: DAB, SSA Region V.

[f] Based on December 1979 data provided by SSA Region V.

[g] Except for certain indicated categories, the prevalence of alcohol abuse was estimated at 8.19% of all beneficiaries. This percentage was derived from a statewide estimate of 258,296 adult alcohol abusers out of 3,154,732 Wisconsin residents aged 20 and over, per the 1980 census.

[h] This report assumes that all these beneficiaries were alcohol abusers.

[i] Except where noted, the prevalence of active CRA's was estimated at .9408% of estimated adult alcohol abusers.

[j] The number of persons who were still drinking to intoxication and using the public emergency care and treatment system, is not known. These figures are rough estimates.

Of the estimated 90 persons who are still CRA's, possibly more than 80 may be using their SSI and/or SSDI payments to continue their addiction. In effect, there is a double standard for those alcohol abusers who are determined to be eligible for SSI on the basis of their abuse and those alcohol abusers who are determined to be eligible for SSI and/or SSDI for some other reason. Persons in the former group, numbering probably no more than 30 in 1981, must accept treatment and forgo financial independence regarding their SSI payments in order to recieve these payments. Persons in the latter group, numbering approximately 9,000 in 1981, need not undergo treatment for their addiction and are free to spend their payments according to their desires. For these alcohol abusers, SSI/SSDI may perpetuate rather than discontinue their abuse.

It is in this light that the findings of an investigation of reports of frequent reversals of initial SSA disability claim denials, discussed above, should be viewed. If, as was recommended in the Task Assignment 1.8 Final Report on the SSI Supplement program, legal advocacy agencies were vigorously to pursue initial SSA disability claim denials for alcoholics and other drug abusers by appealing these decisions, and if they were to succeed in these appeals, it seems likely that their victories could be for the wrong reasons and with the wrong results. The applicants would likely have other impairments in addition to their alcoholism or other drug abuse, these impairments would likely be the reason for the reversal of the initial denial, and the benefits would therefore be awarded directly to the applicants, with freedom to spend at their discretion and without the requirement of accepting treatment for their addiction.

c. SSDI and SSI Recommendations Regarding Subissue B2 (Insufficient Funding)

Five major facts emerge from the preceding discussion. First, there are very few persons participating in the SSDI and/or SSI programs explicitly on the basis of their alcoholism. Second, for these few persons SSI is probably a beneficial program because it requires active treatment and payment of benefits to representative payees as conditions of participation. Third, there may be as many as 9,100 other alcohol abusers (including 80 active CRA's) who are participating in the SSDI and SSI programs for some reason other than their abuse. Fourth, for these persons SSDI and SSI are probably not beneficial, to the extent that they neither require nor encourage treatment for their abuse; for these same persons, SSDI and SSI are probably harmful to the extent that "benefit" payments go directly to addicted "beneficiaries." Finally, prospects for enrolling alcoholics and other drug abusers in the SSDI and SSI programs on the basis of any disability appear dim, because the federal government has recently made more stringent its interpretation of disability eligibility criteria.

In the light of these findings, the following recommendations and rationales are offered:

Recommendation 7: The Department should not take steps to enable greater receipt of SSI benefits, for whatever reason, by practicing alcoholics or other drug abusers, unless these benefits go to a representative payee and active treatment is undergone by these alcoholics and other drug abusers.

Rationale: The provision of SSI payments directly to alcoholics and other drug abusers without control and required participation in an active treatment program is likely to result in continued addiction and abuse, not recovery. Public funds should not be spent to promote even well-intentioned programs that facilitate the continuation of addiction and abuse. Approximately 9,100 Wisconsin SSI recipients who regularly abuse alcohol or other drugs or who are alcoholics or drug addicts but whose abuse or addiction is not perceived as primary by disability determination officials, are probably being enabled to continue their abuse or addiction by SSI. The Department should not promote the enrollment of additional persons who would probably be similarly enabled. This recommendation significantly qualifies that made by Task Assignment 1.8, to promote greater participation in SSI by alcoholics and other drug abusers.

Recommendation 8: The Department should attempt to identify, or have identified, SSI recipients who are eligible for the program for some reason other than primary alcoholism or drug addiction but who have been given a secondary diagnosis of alcoholism or drug addiction, and take one or more of the following steps: 1) ask the SSA to consider changing their classification to DA and A (primary alcoholism or drug addiction) or 2) ask the Wisconsin Congressional delegation to introduce legislation which would facilitate such an SSI reconsideration and/or 3) ask the SSA to grant Wisconsin permission to require the participation of these identified alcoholics or drug addicts in an active treatment program as a condition of receiving their SSI supplement.

Rationale: The current use of SSI payments (the federal base and the current federal/state supplement) by persons diagnosed as alcoholics or drug addicts should not be permitted to continue unless these persons are undergoing active treatment for their addiction. The current year may be propitious for implementing this recommendation, for three reasons. First, the current transition period to full state payment of the SSI supplement provides an opportunity to develop this incentive for intervention and treatment. Second, because the BSSDI's systemic review of virtually all SSI disability claims for severity of impairment is scheduled to begin in January of 1982, the proposed review of alcoholism or drug addiction status would not seem to add significantly to the expected workload. Admittedly, however, a categorical review related to possible DA and A claims might not be possible without explicit Congressional approval. Even with this approval, it is possible that a class action suit alleging discrimination would be filed on behalf of claimants who are SSI eligible for some reason other than DA and A. In this case, a possible compromise might be to hold them harmless and introduce close screening for future DA and A candidates. Finally, with its current mandate to scrutinize the SSI roles, the SSA might welcome the opportunity to offer a "take-treatment-or-else" ultimatum to some SSI recipients. Regardless of any SSA action along these lines, the Department would be provided with a data base which it could use to require the acceptance of treatment as a condition of receiving the supplement when all federal financial participation in that supplement is phased out (by the end of federal fiscal year 1984).

Recommendation 9: The Department should, first, make a formal request from the SSA for more current data regarding national/regional/state ratios of claims reviewed under the criteria of non-psychotic functional disorders to all disability claims. Second, if the Department finds that current national and regional ratios are as divergent as the 1979 ratios, it should, with other states in DHHS Region V, ask for an investigation of disability claims review practices, with special attention to these ratios, resulting in a determination as to why this Region is significantly below the national average in such claims as a percentage of all disability claims.

Rationale: The significant difference between Region V (.07%) and the entire nation (.2%) implies the application of determination criteria that are less objective than would be suggested by Regional variations in population characteristics, disability incidence, advocacy, and other more objective factors. This recommendation would be the first step towards confirming and correcting a possible misapplication.

Recommendation 10: The Department should study cases of former and current DA and A SSI recipients to learn about the mechanics and the effectiveness of the program in bringing about recovery.

Rationale: With the possibility of enhanced discretion in use of Medicaid (Title XIX) funds, the Department needs to review existing programs, such as SSI/DA and A, that allow funds to follow recipients and tie payments to treatment. The Department needs to identify those programs or program elements that seem to offer more cost-effective approaches. It should be noted, however, that the federal Privacy Act might circumscribe access to client files.

2. Medicaid

a. Background and Findings

As with the SSI program, it is not clear how many CRA's are enrolled in the Medicaid program (Title XIX of the Social Security Act). Because all SSI recipients are automatically eligible for MA, there possibly were in 1980 90 active CRA's enrolled in MA, with possibly as many as 9,000 SSI-based other non-CRA alcohol abusers also enrolled. Finally, possibly 3,000 additional non-CRA alcoholics and alcohol abusers (or approximately 1% of roughly 300,000 AFDC-based and other MA recipients) were enrolled in MA.

AODA-related services that are reimbursable by Medicaid include the following:

1. Medical detoxification, when it is provided in an inpatient general hospital setting.
2. AODA inpatient treatment programs, when they are provided in a general hospital setting.
3. AODA outpatient treatment programs, when they are provided in a general hospital setting or clinic.
4. Drugs, when administered during detoxification or as part of an approved treatment program.
5. AODA counseling (included under the psychotherapy label), when it is prescribed by a physician and provided by a certified AODA counsellor or physician, and
6. Transportation to obtain medical care.

Until the publication of the 1981-83 Biennial Budget Act in July and the Budget Adjustment Act in November of 1981 (Chapters 20 and 93, respectively, of the Laws of 1981), all MA-eligibles had been entitled to these AODA-related services (except those aged 22 to 64 for inpatient AODA treatment). Currently, however, only persons who are categorically eligible for MA are entitled to all of these services. The categorically eligible consist of SSI (Title XVI) and AFDC (Title IV-A) recipients. Those MA-eligible persons who are medically needy, on the other hand, are no longer entitled to MA-reimbursable

AODA counseling (psychotherapy) and most legend drugs, though they are still entitled to antibiotic, anticonvulsant, psychotropic, and muscle relaxant drugs. In addition to precluding access of some MA-eligibles to certain optional MA-reimbursable services, recent state legislation has restricted their access to other services by requiring them to make modest copayments.

For each of the covered services, the federal government pays approximately 58% and the state pays the remaining 42%, with two exceptions. First, for AODA counselling (psychotherapy), the county 51.42 Board that must approve the counselling for it to be MA-reimbursable pays 10% of the total charge. Second, for AODA inpatient treatment in a general hospital, the county 51.42 Board pays either 10% or 20% of the charges (depending on whether or not the Board operates a psychiatric hospital) for persons aged 22 to 64.

While MA covers a variety of AODA-related services for most enrollees, it does not cover some other AODA-related services. Among these excluded services are social setting detoxification, transitional community living, and extended care in facilities that do not provide skilled nursing (SNF) or intermediate nursing care (ICF).

b. Analysis

While the trends of reduced coverage and copayments may be expected to continue during the 1981-83 and 1983-85 biennia, it is possible that other more far-reaching changes may affect MA-eligible CRA's during this period. One such change currently under examination by HHS might result in a grant to states of authority to experiment with home and community-based alternatives to long-term institutional care. For older CRA's especially, such a change might open up MA funding to transitional living arrangements, non-SNF/ICF extended care living arrangements and social setting detoxification. As with many other services excluded from MA coverage, these three services are typically provided with little or no medical supervision; yet they often provide less expensive and at least equally effective alternatives to medical model emergency and long-term care.

Another change, soon to be studied by the Department, might result in a three-tiered MA financial system, based on a person's MA-eligibility status: able-bodied poor, elderly, or disabled. Depending on his or her eligibility status, an MA recipient's care might be contracted with private insurers, hospitals, clinics, or HMO's. It is conceivable that care for MA-eligibles who have received a primary or secondary diagnosis of alcoholism could be contracted with a provider offering an array of AODA-related services, such as medical and social setting detoxification, inpatient and outpatient treatment, family counselling, comprehensive case management/discharge planning, and so on. The use of a single provider or authorizer of services might result in more cost-effective treatment for the CRA through detection of the role played by alcohol in producing or exacerbating illness.

c. Medicaid Recommendation Regarding Subissue B2 (Insufficient Funding)

Because little is presently known about the incidence of alcohol and other drug abuse among, and use of AODA-related services by, Wisconsin MA-eligibles, the following recommendation is offered.

Recommendation 11: The Department should determine from its Medicaid Management Information System (MMIS) how many MA enrollees have primary or secondary diagnoses of alcoholism or other drug abuse and profile a sample of these recipients' medical histories to determine the extent to which they received AODA treatment, the extent to which they suffered from other major organic damage, and their relative use of inpatient versus outpatient treatment.

Retionale: To revise the MA financial system and develop home and community-based alternatives to long-term institutional care, the Department would benefit from having more accurate data on the incidence of alcoholism and other drug abuse among MA-eligibles. Not only might special financing or care arrangements be developed for this population based on these data, but other arrangements for more generic groups (such as able-bodied poor, disabled, and elderly) might be made sensitive to the interactive effects between illnesses and alcohol or other drug abuse.

3. Veterans Administration

a. Background and Findings

As noted elsewhere in this report, slightly less than half (47%) of CRA's in Wisconsin are veterans and, therefore, eligible for medical services through Veterans Administration hospitals (Madison, Wood and Tomah) and a VA nursing home (in King). The Tomah Medical Center serves as a psychiatric hospital. All three hospitals have both acute care and long-term care beds and include outpatient components. Only the Wood and Tomah Medical Centers, however, provide AODA inpatient and outpatient treatment, even though it is estimated that between 50% and 75% of all VA beds are occupied by persons for AODA-related reasons. According to the medical director of the Madison VA Hospital, detoxification is not provided because very few veterans became alcoholic while they were in the armed services. Table 8 shows recent use of the Tomah and Wood facilities:

Table 8

Alcohol Abuse Patients Treated at Wisconsin VA Medical Centers*

	Inpatient		Outpatient	
Center	1978	1979	1978	1979
Tomah	303	304	422	467
Wood	760	1,067	446	492
TOTAL	1,063	1,371	868	959

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*Includes only those patients for whom alcohol was the primary diagnosis and who actually received treatment for their alcohol abuse. These numbers are not unduplicated.

It is not known how many of the estimated 47% of CRA's who are veterans received alcohol abuse treatment at either of these Centers.

First priority for free VA care goes to veterans who have service-connected disabilities even if not combat-related. Free care is next available to veterans who are over 65 or certifiably poor. Other veterans are treated free as space and resources permit. The VA generally does not pay for medical services provided in other than VA facilities. Administrative rules, however, do allow veterans who live 50 or more miles away from a VA facility to receive VA-reimbursable emergency treatment at a community hospital.

Finally, the World War II veteran cohort is just beginning to reach age 65, with major implications for VA medical care facilities and expenses. According to the VA's deputy chief medical director, the number of veterans aged 55-74 increased by 17% between 1975 and 1980. During the 1980's, the number of veterans over 65 is expected to increase by 260%, from 3 million to 10.8 million.[19]

b. Analysis

Through its hospitals, nursing homes and domiciliaries, the VA, like other community hospitals and nursing homes, is probably already paying heavily for acute and long-term care for CRA's--by treating the results of years of sustained and excessive drinking by alcoholics who in many if not most cases, would have repeatedly used public detoxification services had they been available. In fact, to the extent that detoxification and treatment services were not more available to these veterans, some of them probably deteriorated to the point where they experienced major organic damage and mental impairment and required institutionalization. In this light, the contention that detoxification services are not warranted in VA hospitals because few veterans became alcoholic while serving in the military may be misplaced. In the first place, while it is often not clear at what precise point a person who abuses alcohol becomes alcoholic, it is evident that in many ways the armed services enables heavy drinking and has done so for many years. Very low prices, full supplies, easy accessibility, and (especially for officers) training and pressure to offer or serve alcohol plentifully and properly are all characteristics of the armed services experience that contribute to alcoholism among its members. Secondly, about 60% of veterans using the VA system have non-service connected disabilities and could, if provided vouchers and enabled to seek care elsewhere, be served in community facilities. Finally, by making detoxification and alcohol treatment services more accessible or by paying for them through a voucher or some other system, the VA might prevent much human suffering, obviate the need for much more expensive medical care for these same persons ten or twenty years hence, and relieve some of the tremendous pressure its medical facilities will surely experience in the 1980's as seven million additional veterans reach age 65.

The prospects do not appear favorable for widening VA reimbursement of detoxification and other AODA services, either provided or purchased by the VA system, itself. The VA will probably have its hands full servicing the increasing numbers of elderly veterans who will seek its services in the next two decades. Additionally, it is already under pressure to eliminate categorically non-service connected veterans. Thus, widening services to non-service connected alcoholics or reconsidering the judgments that resulted in their alcoholism being determined as non-service connected would be seen by some critics as flying in the face of demographic and fiscal pressures.

On the other hand, the prospects for greater VA provision of or reimbursement for AODA-related services are not totally unfavorable. Both the VA's top administration and veterans' groups strongly support maintenance of medical services to non-service connected veterans. Additionally, the VA is under pressure from other critics to provide more cost-effective treatment. Some veterans' groups, moreover, resent the restriction of VA-reimbursed medical care to VA facilities. Upset with the quality of care at VA hospitals and aware of the rule that allows VA-reimbursement for emergency treatment when VA faciliites are distant, many qualifying veterans have gladly used health care vouchers.[19] When considered together, these three factors suggest that that a strategy designed to exert pressure on the VA to make detoxification and other AODA services more available to veterans, might meet with strong support.

c. VA Recommendations Regarding Subissue B2 (Insufficient Funding)

Recommendation 12: The Department should take steps to encourage greater provision of detoxification services by Wisconsin's three VA hospitals.

Recommendation 13: The Department should request the Wisconsin Congressional delegation to ask the VA to reimburse for detoxification and alcohol treatment services provided to clients who have been identified as CRA's, if there is no VA facility offering those services within 50 miles of the clients' residence.

Rationale for Both Recommendations: Because nearly half of the CRA's in Wisconsin are veterans and entitled to VA medical care provided or, under certain conditions, purchased by the VA, it makes little sense to make detoxification and treatment relatively inaccessible. The CRA's dependence on alcohol typically began, or was enabled by the military, during the service years. Even if the origins of dependence cannot be documented clearly, there is substantial precedent for the VA serving non-service connected disabilities. Finally, many beds of VA facilities are currently occupied by alcoholics whose conditions have deteriorated from years of abuse without the benefits of timely detoxification and appropriate treatment. This mistake should not be repeated.

4. Private Health Insurance

a. Background and Findings

1) Extent of Participation. While Wisconsin statutes mandate coverage for alcohol and other drug services in all private group health insurance plans and require similar coverage in a state-operated individual health insurance plan, virtually no CRA's are enrolled in these plans. Their chronic unemployment or under-employment explains CRA's lack of participation in group plans, which are typically sponsored by employers, while their characteristic lack of financial means explains CRA's failure to subscribe to individual plans, which require substantial first-party liability. Each of these categories of plans, group and individual, is described more fully, below.

2) Group Coverage. Section 632.89(2) (Wisconsin Statutes) requires all insurers, except self-insurers, to provide coverage for both inpatient and outpatient treatment of alcoholism or drug abuse (as well as mental and nervous disorders). The minimum coverage for inpatient treatment is 30 days in a calendar year, while the outpatient's minimum is $500 in the same time period. These statutory floors, in effect since the publication of the 1974 Budget Review Act, are the typical maximum amounts covered by private health insurers. The $500 minimum coverage mandated for outpatient treatment in 1974 has declined in value by 1982 to approximately half its original value. Although the Department is authorized under Section 632.89(2)(d) to adjust this amount by administrative rule at two-year intervals to reflect changes in

the cost of medical care, there has been no change in this minimum coverage since it was enacted. The 1981-83 Biennial Budget Act contained a provision to double the outpatient minimum coverage to $1,000, but this provision was item-vetoed.

3) Individual Coverage. Since July of 1981, Wisconsin has operated a State Health Insurance Risk Sharing Plan (HIRSP) designed to offer comprehensive health insurance coverage for residents who are unable to find adequate coverage in the private market due to their mental or physical condition. Applicants are required to demonstrate an inability either to obtain coverage at less than 150% of the standard risk premium or to obtain coverage outright in the private market-place. The Plan imposes a $250,000 individual lifetime benefit ceiling. Preexisting conditions are covered after the first 30 days of participation in the Plan if they were known during the six months prior to application. All insurers of health services (except, since December of 1981, self-insurers) share in the Plan's operating and administrative expenses, in proportion to the amounts of insurance they underwrite.

All subscribers are liable for premiums, deductibles and copayments. First, the regular (non-Medicare) subscriber is completely liable for the first $1,000 of covered expenses, while the Medicare subscriber is liable for the same amount as the Medicare Part A deductible (which was $204 in 1981). Second, for the amount of covered expenses between $1,000 and $3,500 (or for the Medicare-eligible subscriber between $204 and $1,684), the subscriber is responsible for 20%, or a maximum of $500 ($296 for the Medicare-eligible subscriber). For the amount in excess of these ceilings, the Plan pays 100% and the subscriber is not liable, with two notable exceptions: inpatient treatment for alcoholism and other drug abuse is covered only for 30 days per calendar year and outpatient treatment is covered only for $3,000 per year. Third, the subscriber is responsible for a premium. Until January 1, 1984, the law prohibits the rating plan from exceeding 130% of the standard risk which would be charged under an individual policy providing substantially the same coverage and deductibles. Before that date, deficits are to be recouped by assessments from insurers. After that date, the rating plan is to become self-sufficient.

4) Costs, Utilization, and Effects of Covered Treatment. Although more than half the states have enacted laws mandating health insurance coverage of alcohol and other drug treatment or requiring that it be offered as an option, considerable controversy still surrounds issues of the covered treatment's costs, utilization, and effects. On one hand, insurers are concerned that this coverage will make insurance too costly and discourage potential subscribers. They are also concerned that costs could be artificially inflated and facilities overused. Providers and advocates, on the other hand, generally maintain

that fears of overuse of facilities and cost increases are without substance and that use and cost often decline following the addition of this coverage.

Data on Wisconsin's seven years of experience with mandatory group coverage were not available from insurers or the Insurance Commissioner's Office. In the absence of these sources, data from other sources assume prominence. Most studies show extremely low levels of utilization of covered alcoholism services, based on estimated prevalence of alcoholism. A two-year study of a Pennsylvania plan, for example, found that only .04% of subscribers, rather than the estimated 3-4%, made use of the newly covered alcoholism services. Regarding effects on use of other health care services, many studies indicate significant declines following treatment for alcoholism. A four-and-a-half-year study of three prepaid group practice plans, for example, found the following significant declines and changes in the extent and nature of use of health care services following alcohol treatment:

- Total health care use (including visits to alcoholism counselors) declined by 23% for alcoholic/alcohol abusing subscribers 13-18 months after treatment. (Their families' total health care use declined by 60% during this same time period.)

- The percentage of health care visits made to physicians declined from 67% before treatment to 47% after treatment.

- The percentage of health care visits made on an emergency basis declined from 31% to 9%.

- Alcoholic subscribers experienced a 55% decrease in absenteeism and a 90% decrease in on-the-job reprimands.[21]

While few data are available that disclose the actual cost (if any) of adding coverage of alcoholism services to health insurance, the kind of data cited above suggest that premium increases need not be large and that premium reductions might be justified in some cases. Nevertheless, insurers have typically increased premiums when adding alcoholism services to the list of their covered services. These increases ranged from 9¢ per month for one-person coverage of California civil servants to $120 per month for family coverage in New York. It is not clear, however, whether these cost increases (or any increases) were justified.

While many studies have found no difference in patient outcomes between inpatient and outpatient treatment, some have found outpatient to be more effective.[22] Califorinia civil servants are increasingly relying on outpatient treatment of alcoholism and are experiencing a decrease in total per person alcoholism treatment costs. This is not surprising, considering that inpatient programs typically cost three times as much as outpatient programs. At DePaul Rehabilitation Hospital in Milwaukee, for example, inpatient treatment costs run approximately $5,500 while outpatient treatment costs run approximately $1,300.

Other studies, sponsored by the National Association of Insurance Commissioners and the National Commission on Alcoholism and Other Alcohol Related Problems, promise more detailed information on the cost-effectiveness of coverage of alcoholism treatment in insurance plans. Some of this information will compare inpatient with outpatient services, while other findings will relate to the kinds of alcoholics who were benefitted and the kinds who were not.

b. Analysis

A more immediate issue for the CRA than the nature or the limits of available coverage is how to access the coverage that is available. By the time a CRA is able to participate in a group health plan through his or her employer, he or she is probably well on the road to recovery. Group plans, then, are typically not accessible to the active CRA. Individual policies, however, are available for the active CRA under the HIRSP.

The primary obstacle to the CRA's participation in this Plan is the amount of its first-party liability. The maximum annual out-of-pocket expenses required by the HIRSP for a 45 year-old CRA not eligible for Medicare would be $2,264 in 1982, barring premium increases. This amount would consist of the deductible ($1,000), the coinsurance ($500, or 20% of $2,500), and the premium ($764 for a person aged 45-49). The insurers would be responsible for paying the balance of expenses incurred, up to $250,000. With average annual detoxification expenses, alone, amounting to over $1,800 per CRA for 1980 (and probably approaching $2,200 for 1982), it is apparent that enrollment of CRA's in this Plan may offer a more cost-effective alternative than the present reliance on publicly funded detoxification, even with (or especially because of) the Plan's annual coverage ceilings on alcoholism services of 30 days for inpatient treatment and $3,000 for outpatient.

The factors necessary to making the link between the CRA and the HIRSP successful are enrolling the CRA in the Plan and managing his or her health care following enrollment. Counties could help identified CRA's enroll in the HIRSP and pay their premiums, deductibles, and all or part of their co-insurance. At the same time, they could attempt to require, at the point of enrollment, the management of their CRA's' health care by an HMO or other provider responsible for providing or arranging for comprehensive alcoholism treatment. A contract between the HMO/other provider and the county 51.42 Board could be arranged to facilitate provision of medical and social services. Such an arrangement could become a foundation for the Board's case management of the CRA.

A second issue related indirectly to the CRA concerns the accessibility and duration of outpatient treatment. Although most studies clearly indicate that outpatient treatment of alcoholism is more cost-effective than inpatient treatment, current state statutes give providers an incentive to recommend inpatient treatment to their insured clients. Even providers who are aware of the greater cost-effectiveness of outpatient treatment would be understandably hesitant to establish or expand outpatient programs because they would not be sure of making private-pay collections. Yet data show that, where no incentive exists to favor inpatient treatment over outpatient, the latter is the preferred treatment setting. This is often the case in publicly financed programs. For example, many 51.42 Boards allocate no funds for inpatient treatment, preferring to treat their clients in an outpatient setting. To take another example, the Wisconsin Division of Motor Vehicles (Department of Transportation) reported that out of 9,891 drunken drivers convicted in 1980, statutory mandated assessments (under the Drink/Drive Act of 1977) resulted in 46.2% referrals to Group Dynamics classes, 49.6% referrals to outpatient treatment, and 4.2% referrals to inpatient treatment.[22]

There is some question, however, whether the active CRA would benefit from a liberalization of outpatient coverage. Perhaps the more confined inpatient setting would be more conducive to recovery. Unfortunately, there are no data available addressing this question. In any event, the sparse data that are available show that in the years before they began frequenting detoxification facilities, some public inebriates held responsible jobs and had much more money than at present. These data suggest that intervention at this earlier stage might have prevented their physical, mental, and socio-economic deterioration. Making cost-effective treatment more accessible, through raising the statutory outpatient coverage floor, might facilitate privately financed intervention for pre-CRA's today, and might reduce or obviate their resort to publicly financed detoxification and treatment tomorrow.

c. Private Health Insurance Recommendations Regarding Subissue B2 (Insufficient Funding)

Recommendation 14: The Department should encourage counties to enroll identified CRA's in the HIRSP in order to pay all or most of the first-party liability, and contract with an HMO or other pre-paid health care provider for the comprehensive care of the CRA's.

Rationale: The HIRSP provides an opportunity for counties to purchase effective, case-managed health care for CRA's at no or slight additional cost to what the counties are currently paying for CRA's for detoxification, alone. The combination of inpatient and outpatient treatment and other health care services, available through the HIRSP, moreover, promises a more effective approach than the current reliance on detoxification. At the same time, counties need to follow up detoxification and treatment

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episodes. Enrollment in the HIRSP offers counties an incentive to develop comprehensive case management of the CRA's by contracting with an HMO or other pre-paid health providers.

Recommendation 15: The Department should attempt to 1) raise the statutory mandatory minimum group health insurance coverage for outpatient alcoholism and other drug abuse treatment from $500 to either at least $1,000 or a specified number of outpatient sessions that is commensurate with $1,000 (current 1982), and 2) extend statutory mandatory group health insurance coverage to the first 60 days of transitional community living (such as halfway houses).

Rationale: Substantial data support the contention that effective, timely alcoholism treatment reduces hospitalization for many physical problems other than alcoholism and thus reduces health care costs for many clients. Extending private health insurance coverage to the first 60 days of transitional community living would enable the Department to reduce the length of inpatient stays from an average of 21 days to an average of 14 days. Finally, other data show that, on the whole, outpatient treatment of alcoholism is decidedly more cost-effective than its inpatient counterpart, at least for some clients, yet section 632.89(2) (Wisconsin Statutes) provides incentives for the use of inpatient treatment. This incentive is inconsistent with the Department's policy of promoting treatment and support in the least restrictive and most culturally typical settings, as expressed in Planning Guideline #1 on Long-Term Support.

Although in most cases the CRA is unable to enroll in or afford group health insurance policies, raising the current coverage floor for outpatient treatment may assist other chronic alcoholics who can purchase such policies to begin or continue their recovery, by restoring the number of outpatient covered visits to the level originally intended by the Legislature. Such a restored minimum treatment level may prevent the deterioration of alcoholics' physical and mental health and the loss of their socio-economic supports to the point where they must resort to the more costly public detoxification and treatment system. This recommendation may be viewed, then, as an element of a strategy to prevent chronic revolving-door alcohol abuse.

5. Sales and Excise Taxes on Alcoholic Beverages

a. Background and Findings

Wisconsin currently taxes the sale of alcoholic beverages at the rate of 4%, the same rate as other sales taxes. This beverage sales tax is expected to raise approximately $8 million in State Fiscal Year (SFY) 1982. Revenues from this sales tax go to the state's general fund, that is, they are not set aside for special purposes of state government. In addition to this sales tax, Wisconsin levies an excise tax on each barrel of beer that is produced in the state. Like the sales tax, funds from this levy go to the general fund.

Recently, a number of other states have resorted to raising their tax rates on alcoholic beverages, cigarettes, and the like, in order to generate additional revenues. (See Appendix N for a listing of states that have dedicated portions of their alcoholic beverage taxes to funding of alcoholism services.) The federal government may consider a similar measure in the next few years. Some of these revenue-raising efforts, however, have encouraged the entrance of organized crime. Particularly noteworthy is the clandestine transporting of low-tax cigarettes from North Carolina for resale in New York, where cigarettes are highly taxed.

b. Analysis

Raising taxes while the cost of living is still hovering around 10% per year and the state is in a prolonged recession is not a particularly appealing policy option. Yet it is widely recognized by policymakers and the public that alcohol and other drug abuse are serious and growing problems for the entire state. A 1979 stratified probability sample of 6,077 Wisconsin residents aged 18 or over revealed that more people considered alcoholism as presenting either some problem or a major problem in their community than any other problem, as shown in the following table:

TABLE 9

Ranking of Community Problems+
(Sample Size = 6,077)

Community Problems	Percentages, "Some Problem"*	Percentages, "Major Problem"*
Alcoholism	77.0% (1)	42.2% (1)
Crime	74.9% (2)	18.6% (6)
Drug Abuse	74.1% (3)	35.6% (2)
Juvenile Delinquency	72.1% (4)	23.9% (3)
Unemployment	65.5% (5)	15.2% (8)
Job Dissatisfaction	61.6% (6)	19.6% (5)
Improper or Inadequate Diets	57.8% (7)	22.4% (4)
Childrearing Problems	57.1% (8)	13.9% (9)
Unwanted Pregnancies	56.4% (9)	17.5% (7)
Child Abuse/Neglect	51.0% (10)	--
Problems of Physically Handicapped	--	10.8% (10)

+ From the Wisconsin Department of Health and Social Services, Wisconsin: Social Issues and Health Concerns, a Wisconsin General Population Survey, Volume I: a Problem Identification Report, Madison: DHSS, Division of Policy and Budget, November 1979, p. 12. A difference of 2 or more percentage points is considered statistically significant (at the 95% confidence level).

* Figures in the parentheses indicate the rank order of that problem.

Only "drug abuse" was considered by nearly as many respondents as presenting a major problem. Interestingly, crime and juvenile delinquency, which are considered closely associated with excessive drinking or other drug abuse, were rated the next most frequently by respondents as presenting some or major problems. Finally, this statewide pattern was, for the most part, repeated in all of the state's regions.

In addition to its social dimensions, alcoholism has the following economic effects in Wisconsin:

TABLE 10[+]

Economic Costs of Alcohol Abuse and Alcoholism in Wisconsin - 1975

Item	Cost (million)
Lost production	$405.89
Health and Medical	263.29
Motor Vehicle Accidents	106.23
Violent Crime	59.11
Social Responses	40.10
Fire Losses	8.89
TOTAL	$883.51

[+] From the U.S. Department of Commerce, Statistical Abstracts of the United States - 1978, Washington, D.C.: U.S. Department of Commerce, Bureau of the Census, Table 24, "Personal Income in Current and Constant (1972) Dollars - States - 1960-1977," and the National Institute on Alcohol Abuse and Alcoholism, Third Special Report to the U.S. Congress on Alcohol and Health, Washington, D.C.: NIAAA, - June 1978.

If the sales tax on alcoholic beverages were raised from 4% to 5%, effective July 1, 1982, general fund revenues would be increased by approximately $11.1 million in SFY 1983. Because the higher tax rate would not be significantly out of line with contiguous states, the differential would probably not attract organized crime interest. An increased levy on beer production of $1.00 per barrel would generate approximately $5.4 million in SFY 1983. Such an increase, however, might further encourage Wisconsin beer manufacturers to look for more favorable business climates.

Finally, there is some precedent for earmarking sales tax revenues to state programs in alcohol and other drug abuse. Several states have recently begun to use the revenues derived from their taxes on alcoholic beverages to fund their alcohol and other drug services, in the same way that Wisconsin's segregated revenues are earmarked for specific services or activities.

Whether a portion of current sales tax revenues from alcoholic beverages or revenues from an increase of 1% or more in this sales tax should be set aside for alcoholism services is unclear. Also unclear is whether these revenues should be set aside for specific programming for the CRA, folded into the Community Aids program, or used in some other way for alcohol and other drug abuse programming. What is clear, however, is that the state should closely examine a variety of policy options for alternative or supplemental funding of alcohol and other drug abuse programs.

c. Sales and Excise Taxes Recommendation Regarding Subissue B2 (Insufficient Funding)

Recommendation 16: The Department should request the Council on Alcohol and Other Drug Abuse (CAODA) to study a variety of tax-related options for alternative or supplemental funding of alcohol and other drug abuse programs. The study should be completed by January 1, 1983. The study should examine, but not be limited to, the following options:

1. *Raises only the sales tax on alcoholic beverages from 4% to 5%.*
2. *Raise also the taxes on the manufacture and distribution of alcoholic beverages.*
3. *Raise also the sales tax on over-the-counter (OTC) drugs.*
4. *Allocate a portion of revenues from current taxes on alcoholic beverages to AODA programs.*
5. *Allocate the revenues derived from any increase in tax rates on alcoholic beverages and OTC drugs to AODA programs.*
6. *Allocate a portion of revenues derived from either current taxes on alcoholic beverages or an increase in the rates of these taxes to special programming for CRA's.*

Rationale: Alcoholism and other drug abuse are perceived by the general public to be problems in each community. In fact, in a recent survey of Wisconsin adult residents each was cited more than any other phenomenon as either some problem or a major problem. In addition, possibilities of fiscal assistance from the federal or local governments are remote, and from the private sector only slightly more promising. By raising taxes on alcoholic beverages, the state would be creating a minor disincentive to continued drinking. By earmarking the increased revenues or a portion of revenues from the current taxes on alcoholic beverages to alcohol and other drug abuse programs, the state would enable those in need of services to receive them, and would thus prevent further deterioration and disruptions in the lives of many individuals and their families. The state would also be making a vital conceptual link that all who drink and participate in the manufacture, distribution and sales of alcoholic beverages share in the problem and thus should share in the solutions, to the extent of their drinking and participation. Finally, the magnitude of this study and its implications for a variety of state agencies suggest that it be undertaken by an executive branch agency, having membership from a variety of executive agencies and the Legislature. The CAODA is especially fitted to make this study.

MAJOR ISSUE AREA C: PROGRAMMING AND SERVICES. DUE TO SOME INADEQUACIES IN WISCONSIN STATUTE 51.45, FEAR OF LAWSUITS, RESTRICTIVE ADMINISTRATIVE RULES (HSS 3), AND THE APPARENT RELUCTANCE ON THE PART OF 51.42 BOARDS TO ADOPT CREATIVE APPROACHES, THE VAST MAJORITY (84%)[1] OF COUNTIES IN THE STATE OF WISCONSIN ARE PURSUING INEFFECTIVE AND INEFFICIENT APPROACHES TO PROVIDING SERVICES TO THE CHRONIC "REVOLVING-DETOX-DOOR" ALCOHOL ABUSER.

SUBISSUE C1: INADEQUACY OF WISCONSIN STATUTE 51.45

During the early 1970's, federal legislation encouraged, but did not mandate, a nationwide shift from the incarceration to the treatment of the public inebriate. States which chose to make this shift were granted a federal incentive of about half a million dollars each year for six years in order to ease the transition. In Wisconsin, the decriminalization of alcohol intoxication became a reality in August, 1974, as the state began to implement the Wisconsin Alcoholism and Intoxication Treatment Act (s. 51.45). The essence of this law was to cease the criminal prosecution of alcohol abusers and to afford them a continuum of treatment in order that they may lead more productive lives. Crisis intervention, transportation, medical screening/examination, detoxification services, and inpatient and outpatient treatment are the principal services being provided to the public inebriate.

As alluded to earlier, since the implementation of the law, Wisconsin treatment providers have begun to recognize a type of client they refer to as the chronic "revolving-detox-door" alcohol abuser. This special type of public inebriate is characterized by repeated admissions for medical screening and detoxification services. This kind of behavior tends to be associated with the later stages of the illness alcoholism. Despite attempts by treatment providers to advise these clients to seek help for their problem, CRA's continue to drink and experience the progressively debilitating effects of alcoholism. The fact is, the law has been fairly effective with a large proportion (35-50%)[2] of public inebriates, but has been generally ineffective with the so-called chronic "revolving-detox-door" client (1-5% will seek further help for their alcohol problem).[3] Many CRA's even refuse advice to get treated for serious medical problems such as high blood pressure, enlarged liver, elevated blood sugar level, and stomach ulcers.

How big is Wisconsin's problem? Some introductory comments in this report provided an overview of some of the dimensions. The following tables give an estimate of its magnitude:

Table 11

Scope of the Problem in Wisconsin

CY 1980

Estimated prevalence of alcohol abusers (age 21 and over) in the state of Wisconsin,[23]	258,295
Estimated number of alcohol abusers receiving any alcohol services, (age 18 and over)[5]	29,370
Estimated number of alcohol abusers (including revolving-door clients) receiving only detoxification services, (all ages)[5]	8,338
Estimated minimum number of active chronic "revolving-detox-door" alcoholics and alcohol abusers (CRA's), (all ages)[1,5]	2,430

Table 12

Repeated Use of Detoxification Services[1,5,9]

CY 1980

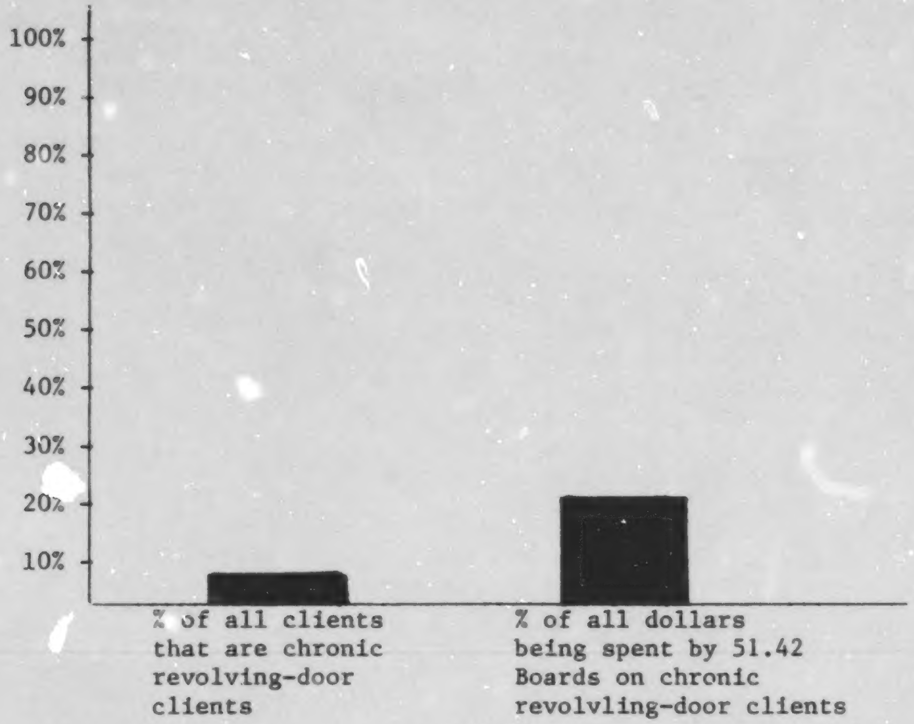
Admissions to Detox	Typical Public Inebriate	Revolving Door Public Inebriate
A single admission to detoxification services	4,089	
Two admissions	1,819	
Three to Five		796
Six to Twelve		518
Thirteen to Twenty		637
Over twenty admissions		479
	5,908	2,430

As can be seen by the figures, the CRA represents about 1% of the total alcohol abusers in the state; 8% of the alcohol abusing clients served by 51.42 Boards; and 29% of the public inebriates served in detoxification services.

Taking these figures as well as data from the fiscal impact of the CRA, the following graph results:

Figure 4[5,6]

Comparison of 51.42 Board Alcoholism Clients and Expenditures
CY 1980



Obviously, decriminalization of public drunkenness did not all of a sudden create a population of "revolving door" alcohol abusers. But rather, the individuals who had been criminally prosecuted over and over again through the courts, have now been diverted to costly medical services. Although these services (medical screening and detoxification) are necessary and of high quality (in terms of professional, safety, and health standards), they are of little benefit in motivating these 2,430 CRA's to lead more productive lives.

While 98% of 51.42 Boards report the existence of CRA's,[1] during our interviews with community alcohol detoxification service staff,[8] we found agreement that the number of chronic revolving-door clients was not increasing but was remaining stable. Death, transiency, incarceration, and some success, have kept the numbers steady. In contrast to this finding, Fagan and Mauss[9] found a 14% increase in the number of incidences (not individuals) of public intoxication in years following the enactment of decriminalization laws in the state of Washington. It is our considered judgment that Wisconsin has seen and will continue to see similar increases. Combining these increases with the austerity of our fiscal situation at the federal, state, and county levels, efficiency has to become an overriding concern in the provision of health and social services. Since, for the chronic "revolving-detox-door" alcohol abuser, traditional approaches to providing services have proven costly and ineffective, alternative means need to be explored.

Certainly, one alternative would be simply to eliminate detoxification services or put a limitation on their use; the rationale being, if we do away with the expensive service, perhaps both the costs and the CRA problem will diminish. Unfortunately, the results of this type of action would cause these CRA's, in the short run, to resort to extreme measures in order to survive. They may break the law, just to get a place to sleep-off the drunk bout. Without adequate care, they may turn to private citizens in the form of panhandling or begging for a place to stay in order to survive. Others would become very ill, to the extent that an even more expensive hospital emergency room service would be required. Still others would die from the effects of withdrawal from alcohol without proper help.

Also, detox isn't just for the CRA. It's for any citizen who's put him/herself into a life-threatening situation as a result of drinking too much alcohol. If this service were eliminated, non-CRA's would also suffer. In the long run, since detox is the entry point for some 35-50%[2] of the persons who are successfuly treated, its elimination would do more harm than good (see Appendix G for graphs illustrating the impact of the alcohol problem).

A second alternative would be to recriminalize alcohol intoxication, as it was in the early 1970's. This action would certainly result in the reburdening of the already overtaxed criminal justice system for the handling of the public inebriate. Costs would not be reduced, and assuredly we would not be seeing any amount of recovery success with the public inebriate or the CRA.

To be sure, the problem is associated with s. 51.45, but only in its misguided emphasis in dealing with the CRA on a voluntary basis. This part of the law is certainly effective with the majority of public inebriates, but is ineffective in dealing efficiently with the revolving-door client who consumes 78%[7] of the detoxification service dollars. At the most, these CRA's can be held involuntarily in a detox program for 72 hours (51.45 (11)(c)). After that, they are free to go drink again and soon return to detox. Although the law does make longer term involuntary commitments (30 to 210 days) possible, very few counties avail themselves of this provision, for the following reasons:[10]

- Many judges will not rule a commitment unless they feel the client will benefit (51.45 13g).

- The inability to secure three persons knowledgeable of the client to testify for a commitment.

- The inadmissibility of program records as evidence to commit a client.

These commitments need not necessarily be to residential programs but could be made to coerce the CRA into following a tailor-made recovery plan utilizing case management and other services mentioned under Subissue C4.

Recommendation #17: The Department should endeavor to amend (underlined) s. 51.45 as per the following:

(12) Emergency Commitment

(a) An intoxicated person who has threatened, attempted or inflicted physical harm on himself or herself or on another and is likely to inflict such physical harm unless committed, or a person who is incapacitated by alcohol, or a person who has abused the intent of the law by exorbitant repeated use of the treatment, may be committed to the community board . . .

(13) Involuntary Commitment

(a) 1. Allege that the condition of the person is such that he or she habitually lacks self-control as to the use of alcoholic beverages, and uses such beverages to the extent that health is substantially impaired or endangered and social or economic functioning is substantially disrupted or has abused the intent of the law by exorbitant repeated use of the treatment;

Rationale: Since the primary intent of s. 51.45 was to afford a continuum of services to the public inebriate so that they might recover from their illness, it is evident that allowing unlimited use of detoxification services violates this intent. With the above-mentioned changes in the law, it would become possible to interrupt the revolving door syndrome based upon excessive use of detoxification services. And since two of the principal barriers to affording clients a continuum of services are their refusal to seek help and the inability of 51.42 Boards to obtain commitments, the recommendation would remove such barriers.

SUBISSUE C2: RESTRICTIVE ADMINISTRATIVE RULES (HSS 3)

Another area causing problems in dealing effectively and efficiently with these revolving-door clients, is in the area of the licensing and regulation of treatment facilities by the state. In many instances, the short and long-term service needs of this chronic alcohol abuser are very minimal. Yet Community Based Residential Facility rules and regulations mandate that facilities meet a variety of requirements, such as:

1) A staff member must be awake at all times (HSS 3.11 2d).

2) Clients entering a facility must have a medical examination for the presence of communicable diseases within 90 days prior to admission (HSS 3.12 1c3).

3) Bedrooms may hold no more than 4 persons (HSS 3.41 2b).

4) 60-80 square feet must be allowed per bed.

These are just a few examples of regulations that make it difficult to start up inexpensive yet adequate programs for the CRA. Counties which might wish to purchase detox services from a mission or build an addition to a halfway house would find these alternatives impossible given these kinds of restrictions. As a consequence, counties are left with the sole option of providing costly medical services to this population of CRA's.

Recommendation #18: The Department should establish a study of changes that could be made in HSS 3 (CBRF) that would allow for less costly yet adequate services to the chronic "revolving-detox-door" alcohol abuser.

SUBISSUE C3: 51.42 BOARDS ARE RELUCTANT TO ADOPT CREATIVE SHORT-TERM APPROACHES TO THE PROBLEM OF THE CHRONIC REVOLVING-DOOR ALCOHOL ABUSER.

Truly, 98% of Wisconsin's 51.42 Boards report a problem with revolving detox-door clients. Yet only 16% of the agencies report being able to effectively and efficiently deal with them.[1] Part of this problem is due to the fact that the CRA receives services mostly at the "front end" of the continuum of available services. These front-end services include crisis intervention, transportation, medical screening/examination and detoxification. Very few ever receive inpatient or outpatient treatment, and those who do, generally relapse back to drinking. Much of this problem is due to the 51.45 statute being inadequate to address the unique problems of the CRA. Since the law states that clients may not be denied services simply because they have relapsed or repeatedly used them (51.45 9c), CRA's may utilize the services without limit. In fact, many hospitals provide "charity" services to this revolving-door client when the 51.42 Board runs out of funds to purchase the service. This means that our estimates of the prevalence and fiscal impact of the chronic client are actually low. A client may be denied service at a facility (say an expensive hospital detox ward) only if another appropriate service (51.45 11c) is provided such as a less expensive social setting/non-medical detoxification service; transportation home; etc. This alternate service must, however, meet the needs of the client.

As was presented earlier, detoxification services can range from $10 per day per client on up to $267 or higher. And, since the law does not specifically require an expensive medical service, but rather "appropriate treatment" (51.45, (7)(b)2, (11)(a), (4)(b) and (m)), it seems logical that county agencies should endeavor to secure the least restrictive care for the client who is not incapacitated. The first key to this approach is proper screening/examination of the client (see Appendix H). The second key is having less expensive but adequate treatment available to the county agency.

Currently, there are very few less expensive non-medical/social setting detoxification beds available in Wisconsin. Hence, counties are left to rely on more expensive existing programs. The following table reports the availability and type of detox bed (see also the map on page 62):

Table 13

Wisconsin Alcohol Detoxification Bed Availability[12]
1981

Estimated number of publicly funded medical detoxification beds	318(82%)
Estimated number of non-medical detoxification beds	72(18%)
Total	390(100%)

In states where the public inebriate is still treated as a criminal, it has been found that less than 5% of detox center admissions, even though clients may have histories of seizures or multiple chronic illnesses, need round-the-clock medical supervision.[9] States that have decriminalized public drunkenness (such as Wisconsin) show that between 40% and 60% of detox center admissions will require medical supervision.[8] The range is given because the need varies from county to county. The proportion is higher for decriminalized states because of the increased volume of clients, the severity of their alcohol problems, and the fear of lawsuits. In the state of Illinois, which decriminalized in 1976, only 13% of detox admissions are served in medical detox programs. Taking into account the fact that 82% of the detox beds available in Wisconsin are medical, this demonstrates evidence of over-treatment in the handling of the public inebriate.

Recommendation #19: The Department shall assign BAODA the responsibility for developing and promoting uniform incapacitation and detoxification screening/assessment procedures, as part of intervention services, in order that the most appropriate, least restrictive treatment is provided to the public inebriate.

Recommendation #20: The Department shall assign BAODA to work with the various DCS regional offices to assess particular county agency deficiencies, circumstances, and needs and to provide the necessary consultation which will result in the establishment of a sufficient number of inexpensive non-medical/social setting detoxification beds.

These beds, centers, or programs should adhere to Administrative Rule HSS 61.58: Social Setting Detoxification Program (see Appendix I). Group homes, wet houses, CBRF's, halfway houses, missions, hostels, hospices, Salvation Army, custodial care homes, AA drop-in centers, rented hospital rooms, hotels, foster homes, crisis shelters, boarding homes, and others may be considered for the location of such beds.

SUBISSUE C4: 51.42 BOARDS ARE RELUCTANT TO ADOPT CREATIVE AND EFFICIENT LONG-TERM APPROACHES TO THE PROBLEM OF THE CRA.

Aside from the problems associated with costly medical detoxification services and their repeated use by clients, there exists the problem of 51.42 Boards inability being unable to change the behavior of the CRA. Although it is difficult, we have found several studies indicating that the goal of recovery is attainable in 6-33% of these individuals, if given appropriate help.[13]

One of the most effective forms of long-term help to the chronic alcohol abuser which will increase his/her chances of recovery begins with assertive case management.[14] Case management involves the following activities:

- Outreach/casefinding/early intervention (identifying and initiating contact with the client)
- Building trust and rapport
- Assessment (determining the client's problems and needs)
- Development and implementation of a realistic service plan to fulfill needs or resolve problems (51.45 (9)(d) Wis. Stats.)
- Follow-along motivational counseling and crisis counseling to ensure that the service plan is being carried out.
- Case review (Is the service plan working? Have the client's needs changed? Does the service plan need to be changed?)

Inconsistent or inadequate case management procedures result in clients receiving services solely at the "front-end" (transportation, crisis intervention, medical screening, and detoxification) of the continuum of services available. Wisconsin Statute 51.45 (9)(e) states that the entire continuum of services should be made available to these clients. Unfortunately, due to counties' inability to obtain involuntary commitments, insufficient funds, lack of services, ineffective services, and the client's refusal to seek help, chronic revolving-door clients do not receive the benefit of the continuum of available services.

In a study by Bixler, the following conclusions were drawn regarding the effectiveness of treatment with alcohol abusers:[24]

- Treatment is significantly more effective than no treatment at all
- No significant differences are found when comparing services (e.g. outpatient vs. inpatient, etc.) or settings (e.g. hospitals vs. non-hospital programs)
- Increasing the amount or intensity of a treatment method does not improve outcome
- Ambulatory services (e.g. outpatient) are as effective as residential services.
- Less costly and least restrictive services should be emphasized

During 1978-79, the Bureau of Alcohol and Other Drug Abuse funded seven pilot projects in order to try out some special programs on the CRA. Some projects relied on non-medical residential care; others emphasized frequent counseling/friendship-type contact with the client outside of the office; still others found foster homes for the client. The success of these projects was rather encouraging:

- 33% of the sample of 87 revolving-door clients (the sample clients averaged 8 admissions to detox each year) maintained sobriety for at least one year; 25% showed some improvement; 42% did not change in any way.
- The typical revolving-door client increased his/her income by an average of $170 per month as a result of being in the project.
- The typical revolving-door client reduced his/her drinking days each week from an average of 5 days to 2 days (76% decrease).
- The typical revolving door client was involved less with the criminal justice system (73% reduction in arrests).
- The overall net treatment cost savings for each client served in the sample of 87 clients was $1,235/year.
- The residential (halfway house and extended care) models saved the most money. These programs average $18-23 per day of care.
- The outpatient counseling models increased income the most.
- The foster care models reduced alcohol consumption the most.
- Four of the seven community projects were terminated after federal funding ended due to insufficient local funding.

The overall result is that the research identified several different creative case management models that can be used cost-effectively with the CRA. It should also be noted that these three approaches (residential; unstructured outpatient counseling; and foster care) are not exhaustive. Wet houses, day services, a jail sentence, the Salvation Army, AA and rescue missions may also be viable alternatives in the development of a treatment plan for the chronic client.

It appears that the alternatives most utilized by county 51.42 agencies is the halfway house and extended care for which there are both insufficient funds and bed space. Even though 92% of Wisconsin's 51.42 agencies have access to extended care beds, there exists sufficient bed space for only about one-half of their chronic clients.[1] The remaining CRA's revolve through the system without restriction. The map on page 62 shows the location of services available to the CRA within the state of Wisconsin. As can be seen on the map, only about four of the 51.42 agencies have special CRA care programs.

Our study also elicited information about effective components of a special program for CRA's:[14]

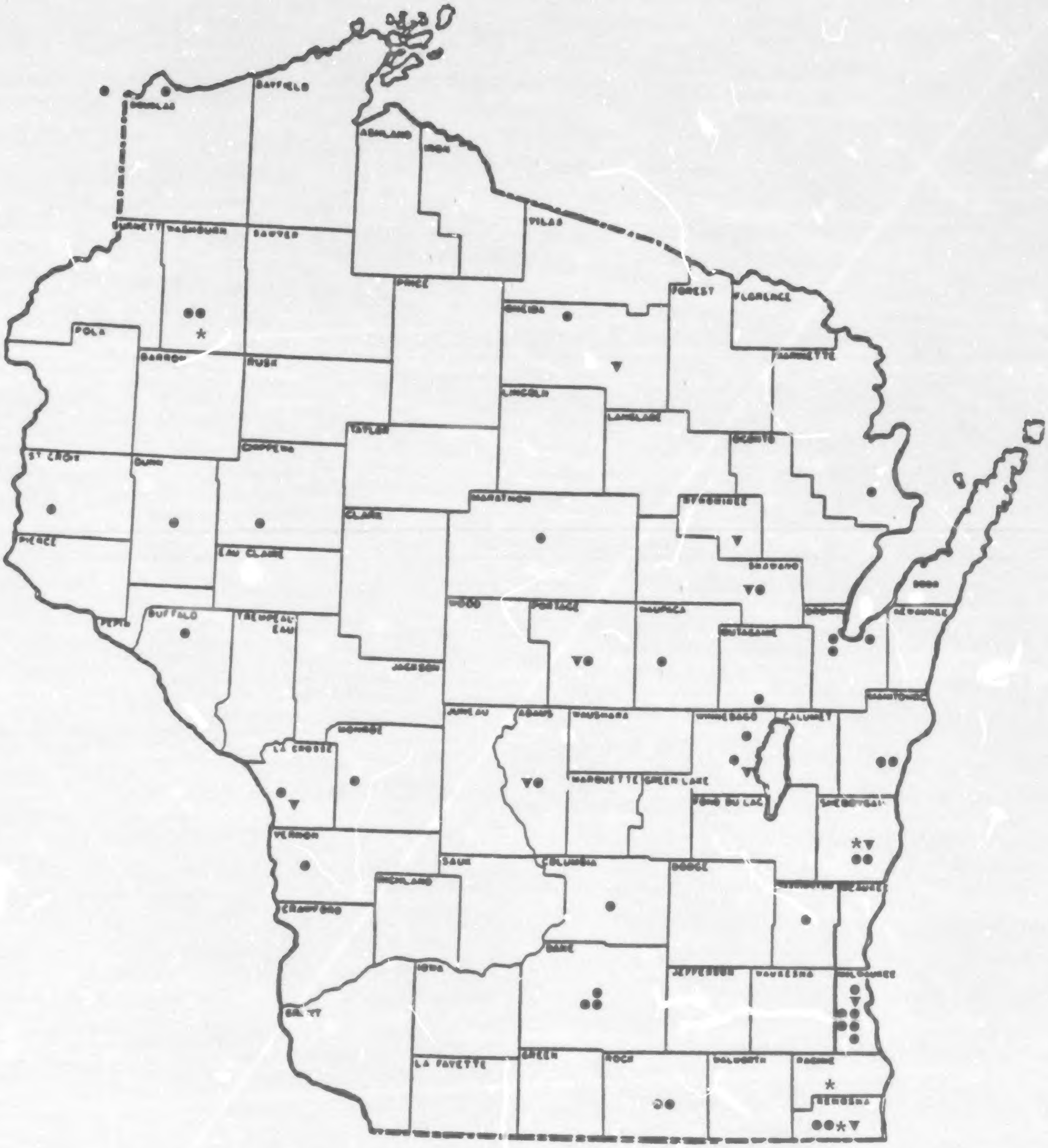
- Assistance in obtaining a job which the chronic client can handle.
- Provide monitored antabuse.*
- Charge clients (fees) for the services they received on a sliding scale. The average income of the typical CRA is about $3,750 per year which allows some room to charge a fee.
- Provide good food.
- Provide a homelike environment.
- Programs should be structured yet flexible enough to allow a client to relapse and still receive help.
- Family or significant other involvement.

The study suggested further that counselors who work with the CRA should exhibit the following traits:[14]

- Discipline/Firmness
- Realistic goal setting (abstinence may be initially unrealistic)
- Dealing with the spiritual needs of the client
- Patience and perseverence with the client despite relapse.
- Personal care and concern for the client

Figure 5
Services Available for the
Unique Needs of CRA's

1981



▼...non medical/social setting detox
●...long term care beds for the CRA
*...special CRA case management

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- 24-hour availability

- Reinforce positive changes the client makes

- Frequent contact with the client

Recommendation 21: *The Department shall assign BAODA and the various DCS regional offices the task of assuring that local 51.42 agencies develop long term service procedures for the CRA, by assessing agency needs and circumstances and then providing the necessary technical consultation. Both voluntary and involuntary long term service procedures utilizing local and state-run services and resources should be considered.*

SUBISSUE C5: CORRECTIONAL INSTITUTION PROGRAMMING FOR ADULT OFFENDERS WHO ARE CRA'S IS INCONSISTENT AND INSUFFICIENT.

Research in criminology has demonstrated a strong association between alcohol abuse and criminal activity. Nationally, alcohol was reported to be present in 72% of robbery offenders,[25] and problem drinkers have been found to represent significant proportions of all offenders in several types of samples: 28% of child abusers,[26] 35% of forcible rapes,[27] and 36% of other assaultive offenses.[28] In Wisconsin, the Crime Information Bureau of the Department of Justice indicated that arrests for alcohol-related and drug-related offenses represent approximately 40% of total Wisconsin arrests,[29] (see Appendix G) and the Division of Corrections (DOC) indicated that 55% of a sample of 427 inmates in 1975 admitted that they were drinking at the time of their most recent offense. In the same survey, 92% of self-reported heavy drinkers were drinking at this time, compared to 60% of self-reported moderate drinkers and 31% of self-reported light or non-drinkers.[30]

This same DOC survey reported that many inmates indicated frequent disruptions in their daily personal lives resulting from their drinking behavior. Of a sample of 552 inmates, 41% were drunk five or more times, 32% drank within the first hour after awakening on five or more occasions, 12% experienced five or more memory lapses, and 10% suffered from the shakes five or more times.[31] A similar pattern of social disruption (at home, on the job, with the law) was revealed by inmates as resulting from their drinking behavior.[32] Finally, the manner of alcoholic beverage consumption indicated by inmates revealed high rates of drunkenness: 32% drank one drink a day every day, 36% drank one to four times a week, 42% routinely drank five to six drinks or bottles each time, and 10% routinely drank three to four drinks or bottles.[33]

These findings suggest that at least one-third of adult inmates in 1975 had histories of serious alcoholism or alcohol abuse. This contrasts with the prevalence estimate of 8.0% reported earlier in this report. This estimate is corroborated by a survey of institutional treatment staff taken at the same time. The range of reported alcohol and other drug abuse ranged from 11% at Taycheedah Correctional Institution (women only, at that time) to 50% at Fox Lake, Green Bay, and Kettle Moraine Correctional Institutions.[34] There is no evidence to indicate that the magnitude of this problem has declined since 1975.

With an average daily population (ADP) of 3,821 adult correctional institution residents in 1981,[35] it is estimated that 1,274, or one-third, were alcoholic or had seriously and chronically abused alcohol prior to this latest incarceration. It was impossible during the course of the Steering Committee investigation to determine how frequently these inmates had used public detoxification services or other alcoholism services. Based on the prevalence estimate of .9408% of adult alcohol abusers noted earlier in this report, it is estimated that possibly 12 inmates were active CRA's before their latest incarceration. Clearly, however, with the drinking problems indicated above, a much larger number of inmates may be considered at-risk of becoming CRA's.

By the end of 1981, the DOC was either operating or preparing to reopen three specific programs that address drug abuse and alcohol abuse needs of adult inmates. Two of the programs are geared specifically for abusers of drugs other than alcohol or for poly-drug abusers. They will not be considered in this report. The program geared specifically for the alcohol abuser is the Corrections Drug Abuse Treatment Center/Alcohol Treatment Unit (ATU), operating out of the Winnebago Mental Health Institute. A fourth program offering general alcohol information to inmates at Oakhill Correctional Institution is too new to describe or evaluate.

ATU is a thirty-bed, voluntary skill-building program for inmates who are either six weeks from release to their home communities or who are within six months from release and are eligible for work or study placement upon completion of the program. It offers services to approximately 180 inmates per year. ATU deals with the concepts of responsible alcohol usage as well as abstinence, depending upon the individual's assessment of need. The three treatment modalities used--social skills (assertiveness) training, relaxation training, and video-taped self-awareness--focus on improving the social skills necessary for the client to maintain a responsible life-style. The program is primarily for those residents who have alcohol related difficulties. Appropriate candidates for ATU have some concept of the negative effects of alcohol use as well as a desire for treatment and personal change. In addition, ATU attempts to provide intervention for those individuals who have experienced chemical abuse difficulties within the correctional system. ATU also considers admitting individuals who are under psychiatric care or psychotropic medication if they are not actively psychotic at the time of referral or entry.

Because it departed from more traditional treatment approaches to problem drinking, a commitment to evaluate the effectiveness of ATU was made at its inception, in 1975. Follow-up interviews made of a control group and an experimental group at intervals of three, six, and twelve months from release to parole supervision or discharge measured a variety of drinking and social functioning variables. It was found that ATU graduates reported drinking less, getting jobs sooner, and earning more than the control group at the three-month and twelve-month follow-ups. Members of the latter group began to experience increasing numbers of shakes and black-outs and began to get involved in fights more frequently than ATU graduates at the 12-month follow-up. ATU graduates, on the other hand, seemed to maintain themselves in their communities much more adequately.[36] While many variables other than ATU may have combined to effect these behavioral changes, the results of the program are promising, and the evaluation warrants replication, once the re-opened ATU is fully staffed and operating in 1982.

In addition to ATU and the Oakhill program, a number of other institution-based initiatives offer alcoholism services. In 1981, DOC began to consolidate its assessment and evaluation services at the Dodge Correctional Institution and to design a screening inventory to be administered to all new inmates so that their alcohol and other drug-related needs could be better assessed. In addition, each adult institution maintains active A.A. groups and provides general casework services to drug and alcohol abusers.

The following recommendations are offered to maintain or improve alcoholism programming at adult correctional institutions.

Recommendation 22: *The Department should maintain the DOC Alcohol Treatment Unit (ATU) at its authorized staffing level, replicate the evaluation of the program that was conducted seven years ago and, if the same findings result, create other small institution-based programs similar or identical to ATU in order to reach at least half (or approximately 650) of the estimated 1,274 chronic and severe alcohol abusers who are in adult correctional institutions.*

Rationale: Seven years' experience and an early evaluation of ATU's predecessor program indicate that the program has probably had some success in reducing ex-inmates' drinking and in helping them otherwise adjust to living in the community. Further analysis needs to be performed, however, because the program staff is virtually entirely new and other, non-programmatic variables might have accounted for the program's effectiveness. Additionally, the costs of the program need to be compared with traditional institutional costs before a decision is made to extend ATU to other locations.

Recommendation 23: *The Department should include the screening instrument for CRA's (Appendix E) which is recommended elsewhere in this report to be field-tested in 1982, in the screening inventory that is being designed for new inmates.*

Rationale: Only a rough estimate of the prevalence of CRA's in adult correctional institutions is available at this time. Use of the CRA screening instrument might enable corrections staff to identify and target programs for the CRA. It is possible that the time spent in prison might be used effectively for CRA's once they are identified and targeted. If not, their drinking history makes them primary candidates to renew their active alcoholism, and possibly also their criminal behavior, once they are discharged or released from prison.

MAJOR ISSUE AREA D: TRAINING OF HEALTH CARE PROFESSIONALS. THERE EXISTS SCANTY TRAINING OF HEALTH CARE PROFESSIONALS IN DEALING WITH THE CHRONIC REVOLVING-DOOR ALCOHOL ABUSER.

It has been widely recognized, and verified by the results of a small study, that medical education in alcoholism and alcohol abuse has been scanty and inadequate. It has also been noted that in the course of their education, medical students acquire negative attitudes and stereotypes towards patients with alcohol problems.

These two deficiencies in medical education led to the establishment of the NIDA-NIAAA Career Teacher Program in Alcohol and Drug Abuse (see page 70). The program emerged in 1970 as a result of a conference sponsored by the National Council on Alcoholism. The NCA had just completed a review of AODA subjects being taught in medical and nursing schools. The study concluded that it was insufficient and that alcoholism was a major cause of medical and psychiatric pathology. Alcoholism was also called the No. 1 public health problem in the United States.

In order to obtain evidence concerning the insufficiency of alcoholism in Wisconsin medical education, a letter was sent to Dr. Roland Herrington, Chairperson of the Alcohol and Other Drug Abuse Committee of the State Medical Society in April, 1981 (see Appendix J). This lead to the Medical Society's request for an inventory of existing AODA curricula in the University of Wisconsin Medical School and the Medical College of Wisconsin. In addition, the Wisconsin Department of Regulation and Licensing, Bureau of Nursing was asked to identify which schools of nursing in Wisconsin currently include chronic revolving-door alcohol abuse in their curricula (see Appendix K). Although a comprehensive search for such curricula in all nursing schools was not possible at this time, a sample of major nursing schools throughout the state was studied. Finally, a search was initiated for chronic revolving-door alcohol abuse in continuing medical education directed at physicians and nurses. The results of these efforts are discussed in the following section of this report.

1. Results and Findings

a. Basic Medical Education: Physicians

Both the University of Wisconsin Medical School (Madison) and the Medical College of Wisconsin (Milwaukee) maintain a significant number of electives and required courses devoted to alcohol and other drug abuse. The UW Medical School requires about ten hours of alcoholism courses but offers more than 100 hours as electives. The Medical College of Wisconsin requires 60 hours, of which 40 are clinical experience at a treatment center, and offers as many as 190 elective hours. Six hours are required in the Department of Pharmacology, 50 hours in Psychiatry, 20 of which are in clinical service, and four hours in Public Health. Ten elective hours are offered in Pharmacology, 40 in Psychiatry, of which 20 are in clinical service, and 140 elective hours in Public Health, of which 60 are in clinical service. In addition, Family Practice

Residents at the Medical College of Wisconsin spend about two weeks in chemical dependency rotation at DePaul Rehabilitation Hospital, a treatment hospital for alcohol abusers in Milwaukee.

In the first year of the UW Medical School program, independent study program students perform exercises in taking social histories of patients at the Dane County Alcohol Detoxification Center. In the second year, there is a one hour lecture on alcohol and addiction in Psychiatry. There are also two and one half hours of lecture and case study devoted to alcohol metabolism and its effects on the liver. There are four lecture hours on drugs of abuse in Pharmacology and a one hour clinical-sociological conference on alcoholism covering genetics, nutrition, case finding and treatment. In the third year, clerkships in Psychiatry and in Medicine allow students to visit alcohol and drug programs and attend a conference on addiction as an elective. In the fourth year, a two-hour lecture on AODA therapeutics is given as an elective in Clinical Pharmacology. There is also a two credit elective course in drug abuse offered in correlation with Clinical Pharmacology. AODA curricula in both programs are guided by the National Institute on Drug Abuse "Statement on Physician Education in Substance Abuse: Curriculum objectives." Neither program maintains electives or required hours on the CRA.

b. Basic Medical Education: Registered Nurses

Seven schools of nursing were surveyed throughout the state in order to determine the extent and adequacy of their education in chronic revolving-door alcohol abuse.

1) University of Wisconsin, Eau Claire

The curricula contain no specific electives or required hours devoted to AODA. Students receive exposure to AODA and associated problems in six hours of lecture in Psychiatry and five hours in Community Health, which includes a segment devoted to family dynamics.

2) St. Joseph's Hospital, Marshfield

The curricula contain no specific electives devoted to AODA. Students receive exposure to AODA through four-to -six hours of required study in the Medical-Surgical area and two required hours of study in the Psychiatric segment of the curricula.

3) University of Wisconsin, Oshkosh

The curricula contain no specific electives or required clinical hours devoted to AODA. Students receive exposure to AODA in four required hours of theory devoted to AODA.

4) Marian College, Fond du Lac

The curricula contain no required hours specifically devoted to AODA. There are electives in AODA given through summer workshops in AODA studies.

5) Marquette University, Milwaukee

The curricula contain eight required hours of theory and thirty required clinical hours in AODA.

6) Moraine Park Technical Institute, West Bend

The curricula contain four required hours of theory, four required hours of visitation to treatment programs, and eight required hours of clinical experience devoted to AODA.

7) University of Wisconsin, Madison

The curricula contain eight required hours of theory devoted to AODA. There is also an elective for clinical experience in AODA.

None of the seven programs surveyed has either electives or requirements devoted to the CRA. Five of the seven have required hours in AODA. These required hours are mainly theoretical presentations. Only one program contains required hours in clinical experience with AODA.

c. Continuing Basic Medical Education of Physicians, Registered Nurses, and General Medical Personnel

The National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism have both concerned themselves with the promotion of AODA curricula in basic medical education and have produced a number of resources in this area. These resources are listed and discussed below.

1) Medical Monographs. A series of texts developed by NIDA concerning medical issues involved in drug abuse. The texts are designed to provide practical information on drug abuse and its treatment. The texts are designed as resources for the practicing physician or as a teaching aid for in-service or pre-service training. The texts may be used as part of a larger program to obtain Continuing Education Units in continuing medical education from the Baylor College of Medicine.

2) Alcohol, Drug, and Related Mental Health Problems. This is a course developed by the National Institute on Alcoholism and Alcohol Abuse at the request of the Federal Bureau of Community Health Services. The course is designed for primary health care providers to address the needs of patients with alcohol, drug, and related mental health problems. The target population of training is composed of physicians, physicians' assistants, and nurse practitioners. The course is particularly valuable for assessment and treatment of problems requiring long-term support, such as chronic revolving doorism.

3) Course on Alcoholism for Primary Care Physicians. This course was developed by a committee of the Association for Medical Education and Research in Substance Abuse, National Institute on Alcoholism and Alcohol Abuse. The purpose of the course is to assist in the development of a continuing education program for the enhancement of proficiency on the part of primary care physicians in detecting, diagnosing, and managing the individual with problems related to excessive alcohol use.

4) National Clearinghouse for Alcohol Information, Project Package for Medical Educators. This is a package of information compiled for medical educators concerned with curricula development in AODA. In addition to this package, the National Clearinghouse is in the process of doing a national survey of alcohol curricula in medical education which should be completed in early 1982. This survey should facilitate resource sharing on a national basis and will greatly aid in curricula development.

5) Career Teacher Programs. This program is jointly sponsored by the NIDA and NIAAA. The purposes of the program are initially to provide support for the development of leadership capability in Schools of Medicine, Public Health, and Osteopathy by increasing the number of faculty knowledgeable in alcohol and drug abuse and subsequently to improve the training which medical students and others receive in these settings. Faculty members receive awards which support advanced training in AODA. These faculty then become responsible to coordinate and promote the education of the professional school's students and faculty in AODA, develop regular courses of instruction in AODA, and develop continuing education programs for practicing physicians and allied health professionals. The program is active at the Medical College of Wisconsin but no longer exists at the UW Medical School.

d. Summary of Findings

Basic medical education of physicians and registered nurses in Wisconsin contains diverse offerings in AODA curricula. In general, the present state of AODA curricula provides a solid foundation for future developments. There are no curricular components devoted exclusively to the CRA and the main thrust of AODA curricula components is to give a general overview of the area in correlation with other relevant aspects of basic medical education, such as psychiatry or pharmacology. This is a reflection of the overall objective of basic medical education to provide the student with a working knowledge of a number of diverse subjects which may be built upon in residency and individual specialization.

A number of resources exists for curricular development in AODA both at the federal and state level. The promotion of AODA curricula in basic medical education for physicians, registered nurses, and allied health professions is a problem area of long standing. Accordingly, a number of resources exist both in terms of actual curricula and technical assistance. While no resources exist which are devoted exclusively to education in the medical management of the CRA, there are courses which touch upon the area in terms of physiological aspects, pharmacology, behavioral comprehension, and assessment. These resources, together with existing AODA curricula in basic medical education in Wisconsin, suggest a number of directions for continuing development of a strategy plan which advocates general AODA curricula in basic medical education and which sensitizes primary health care providers to the need for curricula which deal specifically with revolving-door alcohol abuse.

2. Recommendations Regarding Issue D

The following three recommendations are followed by elaborations and rationales:

Recommendation 24: The Department should ensure adequate coverage of AODA in general, and the CRA in particular, in continuing education programs for physicians and registered nurses.

This effort would involve the interaction of the State Medical Society, the Bureau of Nursing, and the Wisconsin Nurses Association in addition to appropriate personnel from the Bureau of Alcohol and Other Drug Abuse. Both the State Medical Society and the Wisconsin Nurses Association review and approve continuing education programs. These bodies also establish the numbers of Continuing Education Units to be assigned to an approved program. The steps to be taken are as follows:

1) Assemble a whole or partial continuing education program for physicians and registered nurses utilizing state and federal resources. The Bureau of Alcohol and Other Drug Abuse's Alcoholism Treatment Specialist could act as lead trainer with program and trainer development support from the Manpower and Training Unit of the Bureau of Alcohol and Other Drug Abuse.

2) Contact the AODA Subcommittee of the State Medical Society and explore possible roles of the Subcommittee in training program development and implementation. The nature of the training package and curricula needs should be discussed at length with this group. Discussion should be carried on in regard to whether the chronic alcohol and other drug abuser should be the main subject of training or a corollary subject of a training package concerned with more general AODA issues.

3) Contact the Bureau of Nursing and explore possible roles of the Bureau in training program development and implementation. Request that the Bureau become involved in promotion of AODA continuing education for registered nurses.

4) Contact the Wisconsin Nurses Association and explore possible roles they could play in AODA training program development and implementation. The nature of the training package and curricula needs should be discussed at length with this group. Discussion should be carried on in regard to whether the CRA should be the main subject of training or be a corollary subject of a training package concerned with some larger issue. As in the case of the State Medical Society, initial interaction should be carried on by assessing AODA curricular needs for continuing education.

5) Continue to identify and assess the current state of AODA curricula in the continuing education of physicians and registered nurses.

Recommendation 25: The Department should promote additional required AODA curricula hours and/or electives in medical and nursing schools, especially in the area of revolving door alcohol abuse.

This effort would involve the interaction of the State Medical Society, the Bureau of Nursing and the Wisconsin Nurses Association in addition to appropriate personnel from the Bureau of Alcohol and Other Drug Abuse. The promotion of additional curricula in medical and nursing schools must be approached slowly and with maximum involvement from educational institutions and related professional associations. The large number of subjects and the degree of excellence required in medical and nursing schools' curricula, makes additions or changes a difficult process. Consequently, additional required hours or electives in AODA may have to be folded into other areas of curricula rather than introduced as a separate area of curricula. Nevertheless, development of an independent module devoted to the CRA, or clinical experience in this area, should be entertained as possibilities. Initial action must be guided by efforts to sensitize medical educators to the need for special attention to chronic AODA populations and, in return, to respond to the curricular needs identified and given priority by medical educators. Dialogue can be guided by the National Institute on Drug Abuse "Statement on Physician Education in Substance Abuse." The steps to be taken are as follows:

1) Continue to identify and assess the current state of AODA curricula in the basic medical education of physicians and registered nurses. Explore alternative paths to additional or improved AODA curricula and clinical experience utilizing state and federal resources.

2) Continue interaction with the AODA Subcommittee of the State Medical Society, The Wisconsin Nurses Association, and the Bureau of Nursing in regard to AODA curricular development. Explore possibilities of increased involvement among these agencies and the Bureau of Alcohol and Other Drug Abuse in regard to AODA curricular development.

Recommendation 26: The Department should identify general problem areas in basic and continuing medical education which may be resolved through short-term training (e.g. workshops) and formal curricular education, and take steps to develop and implement such training where appropriate.

A number of problem areas involving the CRA and medical personnel may be addressed through training and formal educational curricula. Two existing problem areas include attitudes of medical personnel toward the revolving-door AODA client, and the interface between medical/clinical personnel and other agencies involved with this client.

The attitude of medical personnel toward the CRA is often characterized by feelings of hopelessness and a lack of concern. This is frequently brought about by the lack of success of medical personnel with the chronic patient, a lack of patience with patients who are perceived to lack motivation to get well, and the financial burden of patients who often cannot pay for medical services. Such circumstances often lead medical personnel not to treat the CRA with the same dignity as other patients and to be extremely judgmental about the patient. Both attitudes are extremely counter-productive in dealing with AODA clients, especially CRA's. These attitudes may be successfully altered through training or formal educational curricula which teach medical personnel about the nature of chronic alcoholism and other drug abuse and prepare personnel to manage and treat such clients.

The interface between clinical and other agencies dealing with the CRA is important to improving treatment, developing community alternatives to clinical services for chronics, and alleviating frustration and stress on the part of medical personnel. Training or formal curricular education which exposes medical personnel to governmental and criminal justice personnel managing the CRA would foster awareness of the overall system and increase the willingness of clinical personnel to cooperate and communicate with these agencies. The steps to be taken are as follows:

1) Identify resources for training and curricula to address the problems of attitude and clinical interface for medical personnel in regard to the chronic alcohol and other drug abuser. Current efforts in Justice-Treatment Interface training in the Bureau of Alcohol and Other Drug Abuse should be explored as a potential resource.

2) Contact the AODA Subcommittee of the State Medical Society, the Wisconsin Nurses Association, and the Bureau of Nursing in regard to the possibilities of training, curricular development and clinical experience to address the problem areas of attitudes and clinical interface in regard to the chronic alcohol and other drug abuser.

3) Continue to identify and assess other problems involving medical personnel and the chronic alcohol and other drug abuser which may be addressed by training or formal curricular development.

V. CONCLUSION

An estimated 2,430 chronic revolving-detox-door alcohol abusers presently cost Wisconsin taxpayers about $5.8 million annually, most of which is used for multiple detoxification admissions. At most, 5% of these individuals are motivated toward recovery within the present system of medically-oriented treatment.

It is not surprising, therefore, that detoxification rarely moves CRA's towards recovery, though it does remove CRA's from the life-threatening aspects of acute intoxication, and does seem effective in moving the many 70% of its clients that are not CRA's towards recovery. Inadequacies in s. 51.45, Wisconsin Statutes, fear of lawsuits, lack of funds, misspent funds, restrictive administrative rules, ineffective CRA rehabilitation methods, and the inadequate education of health care professionals all contribute to the alcoholism service system's overreliance on detoxification and under-utilization of more effective alternatives for CRA's.

This report is the result of a comprehensive search of both archival data and community staff impressions about problems and solutions related to CRA's. Thus, the Steering Committee urges the Department to pursue the report's recommendations.

VI. NOTES AND REFERENCES

1. A mail survey of a representative sample (88%) of 51.42 agencies was constructed during June, 1981, in order to obtain information about Chronic Revolving-Door Alcoholics and services to them. See survey instrument in Appendix L.

2. Fagan, Ronald and Mauss, Armand "Padding the Revolving Door: An Initial Assessment of the Uniform Alcoholism and Intoxication Treatment Act in Practice." Social Problems, Vol. 26, No. 2, 1978. Also information obtained from 32 interviews with the following detoxification programs:

    - St. Michaels Hospital, Stevens Point
    - St. Catherines Hospital, Kenosha
    - Harrison House, Oshkosh
    - Zumbro Valley Mental Health Center, Rochester, MN
    - New Visions, Minneapolis, MN
    - Union Gospel Mission, St. Paul, MN
    - Salvation Army, Milwaukee
    - Milwaukee Rescue Mission
    - Brown County 51.42 agency and programs
    - Racine County 51.42 agency and programs
    - Sawyer County 51.42 agency and programs
    - Koinonia, Rhinelander
    - Milwaukee County 51.42 agency and programs

3. Same as (2) above.

4. Paula Johnson, "U.S. Adult Drinking Practices: Time Trends, Social Correlates, and Sex Roles." National Institute on Alcohol Abuse and Alcoholism, July, 1977. Wisconsin estimates are derived utilizing Paula Johnson's National figures.

5. Wisconsin Division of Community Services, Systems and Evaluation Section (Transitional Information System).

6. Survey cited under (1), and (5) above.

7. Fagan and Mauss study (2), and (5) above.

8. Interviews cited under (2) above.

9. Fagan and Mauss study (2) above.

10. Survey cited in (1), and interviews cited in (2) above.

11. Survey cited in (1) above.

12. Griffin, Tim, statistics from the National Drug Abuse Treatment Utilization Survey, which is a descriptive study of Wisconsin's Alcohol and Other Drug Abuse Treatment programs, 1981.

13. Gallant, Bishop, et al "The Revolving Door Alcoholic: Impasse in their Treatment." Archives of General Psychiatry Vol. 28, 1973; the study cited in (14); and O'Briant, Robert "Social Setting Detoxification." Alcohol Health and Research World. Winter 1974-75.

14. University of Wisconsin Survey Research Lab, interviews conducted with former staff of seven projects demonstrating approaches to treating revolving-door alcoholics (see Appendix M). Projects included:

    - Bridgeway, Madison
    - Sheboygan County 51.42 agency
    - CAP, Milwaukee
    - RAMP, Racine/Kenosha
    - Kennedy House, Medford
    - The Pines, Spooner
    - Douglas County 51.42 agency

15. See the Dane County Youth Needs Assessment, Vol. 1: Youth Survey, Madison: Dane County Youth Commission, February 1980, pp. 30-36, which reported that 20% of high school students used alcohol to the extent of producing dangerously high blood alcohol levels and with frequencies which make addiction and other serious problems imminent. Also see the Wisconsin State AODA Plan, Fiscal Year 1982, Madison: DHSS, Bureau of Alcohol and Other Drug Abuse, June, 1981, pp. 55-58.

16. Emrick, Chad "A Review of Psychologically Oriented Treatment of Alcoholism" Quarterly Journal of Alcohol Studies, 1974.

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18. Quirke, Michael, "A Descriptive Study of Eleven Wisconsin Halfway Houses," Bureau of Alcohol and Other Drug Abuse, 1979.

19. Demkovich, Linda, "The Graying of the VA--As Veterans Age, Some May Be Denied Health Care." National Journal, Vol. 13, 1981 p. 1058.

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21. Hallan, Jerome, "Health Insurance Coverage For Alcoholism: A Review of Costs and Utilization." Alcohol Health and Research World Vol. 5, 1981.

22. Mckim, Karen, "Primary Alcoholism Treatment and Cost Effectiveness" staff report to the Health Planning Council, Madison 1981.

23. Same as (4) above.

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25. U.S. Department of Health, Education, and Welfare. Third Special Report to the U.S. Congress on Alcohol and Health from the Secretary of Health, Education, and Welfare. Washington, D.C.: U.S. Government Printing Office, 1978.

26. Swanson, D. W. "Adult Sexual Abuse of Children." Diseases of the Nervous System, vol. 29, no. 10 (1968), pp. 677-683.

27. Rada, R.T. "Alcoholism and Forcible Rape," American Journal of Psychiatry, vol. 13, no. 4 (1975), pp. 444-446.

28. Mayfield, D. "Alcoholism, Alcohol, Intoxification, and Assaultive Behavior," Diseases of the Nervous System, vol. 37, no. 5 (1976), p.p. 288-291.

29. Wisconsin Department of Health and Social Services. Wisconsin State Alcohol and Other Drug Abuse Plan, Fiscal Year 1982. Madison: DHSS, Division of Community Services, Bureau of Alcohol and Other Drug Abuse, June 1981, p. 234.

30. Wisconsin Department of Health and Social Services. Wisconsin Division of Corrections Drug Abuse Survey. Madison: DHSS, Division of Corrections, Bureau of Clinical Services, April 1976, p. 29.

31. Ibid., p. 30.

32. Ibid., p. 28.

33. Ibid., pp. 23, 27.

34. Ibid., pp 5-11.

35. The monthly institutional adult population reports from DOC were used from November 1980 through October 1981 to generate this figure. Adult inmates including those in medical hospitals were counted.

36. Gerald L. Vigdal, Donald W. Stadler, David D. Goodrick, and Dennis J. Sutton. "Skills Training in a Program for Problem-Drinking Offenders: A One Year Follow-Up Evaluation." Journal of Offenders Counseling, Services, and Rehabilitation, (Winter, 1980).

VII. GLOSSARY

Alcohol Abuser, Alcoholic, Public Inebriate, Problem Drinker - Although technically there are differences among these terms, for the purposes of this report, it is not necessary to distinguish them. Hence, these are terms identifying any individual experiencing problems (social, legal, health, economic, etc.) as a result of his/her consumption of alcohol.

Antabuse - A medication used in the treatment of alcoholism which causes severe gastric and abdominal disturbances if taken with alcohol. It is a form of aversion therapy.

Black Outs - A chemically induced period of permanent memory loss. The person is physiologically affected and cannot remember things he/she did or said while drinking alcohol during previous hours or days. It's unpredictable as to when a blackout will occur, the quantity of chemical required to induce a blackout, or how long they will last. Simply stated, it's a form of amnesia induced by alcohol.

Blood Alcohol Concentration - .01 or (10%) is legally intoxicated when driving a vehicle under s. 346.63 (1) b and considered prime evidence of intoxication under s. 885.235 (1) c, of Chapter 20.

Community Service Program (CSP) - 51; 51.42; and HSD; are all synonymous terms representing the county government agency responsible for providing and/or purchasing developmental disability, mental health, and alcohol and other drug abuse services.

Chronic "Revolving-Detox-Door" Alcohol Abuser (CRA)- A person who habitually lacks self-control in the use of alcoholic beverages. This pattern of behavior usually develops in the later stages of alcohol addiction when the individual becomes powerless to stop his/her pathological drinking behavior. The end result is physical, social, psychological, spiritual, and occupational deterioration to the point where he/she becomes overly reliant upon and repeatedly uses alcohol emergency and detoxication services with little or no long lasting change in behavior.

Delirium Tremens (D.T.'s)- an acute mental disturbance marked by delirium with trembling and great excitement, and attended by anxiety, mental distress, hallucinations, sweating, and gastro-intestinal symptoms. Ordinarily seen following withdrawal from heavy alcohol intake.

General Purpose Revenue - General taxes, receipts, and revenues collected by state agencies, a portion of which is returned to counties via a formula to spend on state mandated Human Services and other programs.

Incapacitated by Alcohol - Under Wisconsin Statute 51.45 this means that a person, as a result of the use of or withdrawal from alcohol, is unconscious or has his or her judgement otherwise so impaired that he/she is incapable of making a rational decision, as evidenced objective by such indicators as extreme physical debilitation, physical harm or threats of harm to himself or herself or to any other person or to property.

APPENDICES

State of Wisconsin \ DEPARTMENT OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE SECRETARY
1 WEST WILSON STREET
MADISON, WISCONSIN 53702

TASK ASSIGNMENT #1.11
DHSS PLANNING GUIDELINE #1
Long-Term Support
1979-83 Initiatives Series

TO: ELMER CADY, DIVISION OF CORRECTIONS
NATE HARRIS, DIVISION OF MANAGEMENT SERVICES
PETER TROPMAN, DIVISION OF POLICY AND BUDGET
BURTON WAGNER, DIVISION OF COMMUNITY SERVICES
TERRY WILLKOM, DIVISION OF HEALTH

FROM: Donald E. Percy, Secretary

SUBJECT: Chronic Alcoholism and Other Drug Abuse

Planning Guideline #1 establishes the Department's long-term support goals for chronically and severely needy adults and for the delivery system that serves them. It identifies five target populations: developmentally and physically disabled persons, the frail elderly population, chronically mentally ill persons, and chronic alcoholics and other drug abusers. The Planning Guideline's problem statement emphasizes common themes which point to dislocations in this delivery system, and its individual and systemic goals emphasize generic solutions to these problems.

Clearly, however, all five target populations do not encounter identical problems, nor do they all have the same types and levels of needs. Furthermore, these populations are not all perceived in the same manner by the public and professional human service providers. These different perceptions, needs and problems require some unique approaches for those adults who are chronically alcoholic or who are addicted to other degenerative drugs and for the delivery system that serves them. In recognition of this requirement, a 1980 state plan goal of the Bureau of Alcohol and Other Drug Abuse (BAODA) emphasizes the special needs of chronic recidivist alcoholics and other drug abusers in program planning, treatment, and rehabilitation.

It is the goal of this Task Assignment to examine and explore solutions to some of the most significant of these problems. The following objectives will serve as vehicles to that end.

TASK OBJECTIVES

In order to meet more adequately the needs of chronic alcoholics and other drug abusers, I believe the Department must complete the following activities:

1. As listed in the State AODA Plan, review statewide efforts to provide long-term support to chronic recidivist alcoholics and other drug abusers.

2. Develop specific criteria by which to identify chronic recidivist alcoholics and other drug abusers and distinguish them from other AODA's.

3. Assess the performance of the six chronic alcoholism care models operated in the state during the last two years, emphasizing clients' relative sobriety, use of alcohol treatment services, and cost outcomes.

4. Develop a plan to maximize reimbursement for the long-term support of chronic recidivist alcoholics and other drug abusers from third parties, in general, and from federal programs, in particular.

5. Determine the dimensions and causes of the excessive use by chronic alcoholics of Detoxification services and explore potential remedies for this pattern.

6. Revise program standards for residential and non-residential Extended Care and special living arrangements for chronic recividist alcoholics and other drug abusers, consistent with the principles stated in Planning Guideline #1.

7. Develop a plan to provide: 1) students in health care disciplines in state-funded higher educational institutions with adequate training in the assessment and treatment of chronic alcoholism and other drug abuse, and 2) doctors and nurses with such training as part of their continuing education requirements.

8. Promote assessment, treatment, and post-release programming for adult offenders who are chronic alcoholics or other drug abusers.

Some of these task objectives will lead to recommendations that will need to be operationalized at a later date. At that point, a second task assignment that will essentially contain an implementation plan may need to be developed. While I expect the Department to commit the resources needed to complete these objectives, I also expect that implementation of this Task Assignment's recommendations will not require additional GPR outlays or positions.

TASK RESPONSIBILITIES

The BAODA will assume primary responsibility for carrying out these objectives with appropriate involvement from other portions of DHSS, the University of Wisconsin, the Department of Vocational, Technical, and Adult Education, other state agencies, and AODA interest groups and service consumers. Initial activities on each task objective should include the development of a plan of action which details the steps neccessary [illegible] satisfy the objective.

More specifically, the BAODA will be responsible for formally assigning one of its staff to deal with programming and policy development to meet the needs of chronic alcoholics and other drug abusers. It will also design and conduct an assessment study to determine what long-term support services exist and how much they are needed. Either in this study or a separate one, the BAODA will determine the magnitude and patterns of use of Detoxification services, with assistance from 51 Boards and service consumers. The corrections-related task objective (#8) will be the joint responsibility of the BAODA and the DOC.

COMPLETION DATES

Objective #1: The review of statewide long-term support efforts for chronic AODA's will consist of two parts.

a) Formal assignment of a BAODA staff member to deal with program and policy development for the chronic population should begin immediately and be resolved by September 30.

b) Inventory of existing services and assessment of the need for them should be completed by June 30, 1981, with monthly progress reports provided before this date.

Objective #2: The development of specific criteria by which to identify chronic recidivist alcoholics and other drug abusers and distinguish them from other AODA's should be completed by January 31, 1981.

Objective #3: The assessment of the performance of the six chronic alcoholism care models, including a plan to disseminate information about the successful ones, should be completed by November 30, 1980.

Objective #4: The development of a plan to maximize third-party reimbursement for the long-term support of chronic recidivist AODA's should be completed by December 31, 1980.

Objective #5: The evaluation of usage of Detoxification services, with recommended remedies for its abuse, should be completed by April 30, 1981.

Objective #6: The development of program standards for Extended Care and special living arrangements should be completed by June 30, 1981.

Objective #7: The development of a plan to promote the adequate training of health care students and practitioners in chronic alcoholism and other drug abuse should be completed by June 30, 1981.

Objective #8: A report on better ways of meeting the needs of adult offenders who are chronic alcoholics or other drug abusers should be completed by May 31, 1981.

The work group for this Task Assignment should contain at least the following people: Jerry Vigdal from DOC, Roy Johnston from DPB, Larry Monson or his designee(s) (who should chair the group) from DCS, and Ed Minihan from DOH. Where joint responsibility exists for completion of a task objective, the BAODA is responsible for seeing that completion deadlines are met.

This Task Assignment is to be completed by June 30, 1981. I would like reports on this Task Assignment's progress on each objective addressed in your Division's monthly progress reports.

Division of Community Services February 9, 1981

To: Regional Directors
Regional AODA Program Consultants
Community Service Boards
Community Alcohol and Drug Abuse Programs

From: Burton A. Wagner Nelson for
Administrator

Re: TASK ASSIGNMENT #1.11 - DEPARTMENT OF HEALTH AND SOCIAL SERVICES
PLANNING GUIDELINE #1, LONG TERM SUPPORT
"CHRONIC RECIDIVIST ALCOHOLISM AND OTHER DRUG ABUSE"

Recently, the Department of Health and Social Services issued the above referenced Task Assignment (attached).

The Division of Community Services, Bureau of Alcohol and Other Drug Abuse, has been given primary responsibility for carrying out the assignment with appropriate involvement from other portions of DHSS, the University of Wisconsin, the Department of Vocational, Technical, and Adult Education, other state agencies, and AODA interest groups and service consumers.

The purpose of this communication is to:

1. Direct your attention to objective #2: "The development of specific criteria by which to identify chronic recidivist alcoholics and other drug abusers and distinguish them from other AODA's . . . "

2. To solicit your vital input in developing these criteria.

The attached form is an initial vehicle for soliciting your involvement. The form has been designed to gather your opinions regarding the characteristics of the chronic recidivist and is composed of two parts:

- Part A requests you to rate some characteristics.
- Part B allows you to add your own characteristics that have been inadvertently omitted.

Upon your completion of the form please forward to Chronic Recidivist Criteria Project, Bureau of Alcohol and Other Drug Abuse, 1 West Wilson Street, Madison, Wisconsin 53702 by February 27, 1981.

The results will be published and copies made available to everyone upon completion of the project.

Attachment

cc: Douglas Nelson
John Erickson
John Vick/Dorothy Houden

WISCONSIN DHSS
Division of Community Services
DCS-800 (Issued 2-81)

CHRONIC RECIDIVIST ALCOHOL AND/OR OTHER DRUG ABUSER SURVEY

A. INSTRUCTIONS: Place one check per item in the box that most closely describes your own opinion, experience, or study with regard to the characteristics of the chronic recidivist, male or female. If there is a vast difference between males and females in your experience, place an "M" in the box for male and an "F" in the box for female. Also, if there is a vast difference between the alcohol abuser vs. the drug abuser, put an "A" in the box for alcohol and "D" in the box for drug.

None = In my experience I have never found a chronic recidivist who had this characteristic.

Few = In my experience I have found that a few chronic recidivists will have this characteristic.

Many = I have found that many chronic recidivists have this characteristic.

Most = I have found that most chronic recidivists have this characteristic.

All = I have found that all chronic recidivists have this characteristic.

		None	Few	Many	Most	All	Don't Know
1.	No close family ties	( )	( )	( )	( )	( )	( )
2.	History of automobile accidents	( )	( )	( )	( )	( )	( )
3.	At least ten (10) detox or emergency room screenings for alcohol and/or other drug abuse in one year	( )	( )	( )	( )	( )	( )
4.	At least 5 detox or emergency room treatment episodes per year related to alcohol or drug consumption	( )	( )	( )	( )	( )	( )
5.	Marital status single (never married; divorced; separated; widowed)	( )	( )	( )	( )	( )	( )
6.	Income at or below poverty level	( )	( )	( )	( )	( )	( )
7.	Frequent job changes or sporadic employment	( )	( )	( )	( )	( )	( )

		None	Few	Many	Most	All	Don't Know
8.	Lacks any religious or spiritual belief	( )	( )	( )	( )	( )	( )
9.	Regular weekend alcohol or drug use to intoxication	( )	( )	( )	( )	( )	( )
10.	History of injury related to alcohol or other drug abuse	( )	( )	( )	( )	( )	( )
11.	Over age 45	( )	( )	( )	( )	( )	( )
12.	Unemployable	( )	( )	( )	( )	( )	( )
13.	History of arrests, jail confinements, or police pick-ups related to AODA consumption	( )	( )	( )	( )	( )	( )
14.	Homeless or no permanent residence (transient)	( )	( )	( )	( )	( )	( )
15.	Regular daily intake of alcohol or a drug to intoxication	( )	( )	( )	( )	( )	( )
16.	Is nutritionally deficient	( )	( )	( )	( )	( )	( )
17.	Mental deterioration is evident	( )	( )	( )	( )	( )	( )
18.	Dependence on welfare for sustenance	( )	( )	( )	( )	( )	( )
19.	Has failed at least two times in inpatient treatment, Halfway House or other form of residential treatment	( )	( )	( )	( )	( )	( )
20.	Uses other mood altering substances	( )	( )	( )	( )	( )	( )
21.	Tenth (10) grade or less education	( )	( )	( )	( )	( )	( )

		None	Few	Many	Most	All	Don't Know
22.	History of medical problems related to alcohol abuse or drugs (Hypertension; gastritis; septicemia; cirrhosis; hepatitis; pneumonia; cancer; etc.)	( )	( )	( )	( )	( )	( )
23.	Depressive personality disorder	( )	( )	( )	( )	( )	( )
24.	Life style contrary to accepted norms of the community, (no stable home life; sexual promiscuity; gambling; antisocial; sporadic employment; etc.)	( )	( )	( )	( )	( )	( )
25.	At least 5 years of heavy drinking or drug use	( )	( )	( )	( )	( )	( )
26.	Gets into hassles or heated arguments while drinking or using drugs	( )	( )	( )	( )	( )	( )
27.	Never really tried to quit drinking or using drugs (no dry period longer than 6 months)	( )	( )	( )	( )	( )	( )
28.	History of indebtedness	( )	( )	( )	( )	( )	( )
29.	History of psychological problems and services	( )	( )	( )	( )	( )	( )
30.	Has attempted suicide	( )	( )	( )	( )	( )	( )
31.	Use of AODA services solely at the "front end" of the continuum (i.e. crisis; detox; etc.)	( )	( )	( )	( )	( )	( )
32.	At least one court commitment to alcohol or drug abuse treatment	( )	( )	( )	( )	( )	( )

		None	Few	Many	Most	All	Don't Know
33.	Will experience moderate to severe withdrawal symptoms if deprived of the drug or alcohol	( )	( )	( )	( )	( )	( )
34.	Has no close friends	( )	( )	( )	( )	( )	( )
35.	Parents or siblings have experienced or are experiencing substance abuse	( )	( )	( )	( )	( )	( )
36.	Has long periods of sobriety interspersed with heavy binge-type drinking or drug use	( )	( )	( )	( )	( )	( )
37.	Anti-social personality disorder	( )	( )	( )	( )	( )	( )
38.	Heavy drinking or drug use during adolescence	( )	( )	( )	( )	( )	( )
39.	Does not possess health insurance	( )	( )	( )	( )	( )	( )
40.	Living alone	( )	( )	( )	( )	( )	( )
41.	Failed with antabuse treatment	( )	( )	( )	( )	( )	( )

B. The characteristics listed in Part A of this survey are not exhaustive. For this reason, the remaining portion of this instrument is reserved for your own opinion regarding the characteristics of a chronic recidivist alcohol or other drug abuser (their age; use of detox; life style; patterns of consumption; illnesses; personality; etc.). Please be specific and use the back of this form if necessary. Thank you.

Name (Optional) ____________________

Position ____________________

Agency ____________________

Appendix C

DETOX RECIDIVIST STUDY INSTRUMENT

Respondent ______________________________ Agency ________________________

Respondent's Title _______________________ Name of Interviewer ____________

Medical ( ) Non-Medical ( ) Hospital ( ) Non-Hospital ( )

Brief Purpose Statement: We are conducting this study in order to more adequately understand the behavior of the detox recidivist so that we might be able to devise some solutions to the problem.

Definition of the Detox Recidivsit: Any individual who has been assessed as having an alcohol or drug abuse problem and has repeatedly received public detoxification services resulting in little or no long-lasting change in behavior.

****
****

1. That is our broad definition of the Detox Recidivist. We would be interested in your description of this population in terms of things like the number of admissions to detox; drinking enviornment; living situation; etc.

2. Second, I'd like to know how many recidivists, if any, are residing in this county(s)? Is this actual or an estimate? (If respondent has records, ask if they can be looked at).

(Circle one) actual _______________
estimate

3. Would you say this recidivist problem was increasing, decreasing, or remaining stable in the past 2 years?

Increasing ( ) Decreasing ( ) Remaining Stable ( )

4. What typically happens to the detox recidivist once they appear at the Detox/ER facility?

a. Circumstances leading up to admission:

b. Initial screening procedures: If yes, describe. No ( ) Unknown ( )

c. Commitment procedures: If yes describe. No ( ) Unknown ( )

d. Medical or back-up procedures: If yes describe. No ( ) Unknown ( )

e. Counseling/education/motivation: If yes, describe. No ( ) Unknown ( )

f. Referral procedures: If yes, describe. No ( ) Unknown ( )

g. Follow-up: If yes, describe. No ( ) Unknown ( )

5. Recidivists sometimes cause problems in a community, would you say this is true here? Yes ( ) No ( ) Explain

98

6. Are any of the following problems present at the Detox/ER facility? Would you say they were major, minor, or nonexistent?

		Major Problem	Minor Problem	Not a Problem	Unknown
a.	The facility is unable to keep the recidivist client long enough for motivational counseling to work	( )	( )	( )	( )
b.	Detox recidivists refuse to follow through on referrals to treatment	( )	( )	( )	( )
c.	Families of the recidivists refuse to become involved	( )	( )	( )	( )
d.	Care is so good (i.e. meals; warmth; staff contact) that it encourages recidivism	( )	( )	( )	( )
e.	The fact that the service is free encourages recidivism	( )	( )	( )	( )
f.	The majority of the recidivists we see don't really need 24-hour medical attention. (Probe)	( )	( )	( )	( )
g.	Recidivists are belligerent or uncooperative while at the facility	( )	( )	( )	( )
h.	Recidivists break the rules at the facility	( )	( )	( )	( )
i.	Recidivists are violent while at the facility	( )	( )	( )	( )
j.	Recidivists will con or manipulate staff at the facility	( )	( )	( )	( )
k.	Recidivists will physically abuse staff at the facility (hitting; spitting; weapons; strong verbal threats)	( )	( )	( )	( )
l.	Recidivists will commit vandalism or theft while at the facility	( )	( )	( )	( )
m.	Recidivists leaving AMA (against medical advice)	( )	( )	( )	( )
n.	Recidivists "shop around" to receive detox services.	( )	( )	( )	( )
	(any other)				
o.	____________________	( )	( )	( )	( )
p.	____________________	( )	( )	( )	( )
q.	____________________	( )	( )	( )	( )

7. What would you say are some of the major causes of this recidivist problem? (Probe in-depth)

8. Can you recommend some solutions to the problem of the detox recidivist? (Probe in-depth)

9. If any of your past recidivists have discontinued their use of detox, what contributed to this change in their behavior? (i.e. death; AA; own acceptance of problem; doctor; clergy; family; the accumalated effect of treatment; etc.) Probe in-depth

10. What is the average cost per client per day at this facility?
$ ____________________

11. What proportion of the recidivist admissions really need medical attention? ________________ %

RECORDS DATA

If any of the agencies interviewed keep records on the recidivists, obtain the following hard data on the recidivists:*

Age
19 and under _____
20-24 ...... _____
25-29 ...... _____
30-34 ...... _____
35-44 ...... _____
45-60 ...... _____
61 plus .... _____
Unknown .... _____

Gender
Male ..... _____
Female ... _____
Unknown .. _____

Residence
Same county _____
Other county _____
Out of state _____
Unknown .... _____

Cost/yr
$ 500 or less _____
$ 501 -- $1,000 _____
$1,001 -- 2,000 _____
$2,001 -- 3,000 _____
$3,001 -- 5,000 _____
$5,001 -- 7,000 _____
$7,001 -- 10,000 _____
$10,000 plus _____
Unknown .... _____

Admissions/yr
2- 4 _____
5- 7 _____
8-10 _____
11-15 _____
16-20 _____
21 plus _____

Referral Source
Law enforce _____
Family/friend _____
Counselor _____
Walk-in _____
Ambulance _____
Other _____________
Unknown _____

Avg. length of Stay
2 days or less _____
3-4 days ..... _____
5-6 days ..... _____
7-8 days ..... _____
9 plus days ... _____
Unknown .... _____

Discharge Status
With medical advice .. _____
Against medical advice _____
Unknown .... _____

Source of Payment
Unified Board ..... _____
Private Insurance . _____
Self Pay .... _____
Other _____________________
Unknown .... _____

Detox Facilities Frequented
One .... _____
Multiple ...... _____
Unknown .... _____

Total Recidivist admissions in a given year ÷ total (recid and non-recid) admissions in a given year = _______________

Total Recidivist clients in a given year ÷ total (recid and non-recid) clients in a given year = ____________

Total Recidivist costs in a given year ÷ total (recid and non-recid) costs in a given year = ________________

* For purposes of Research, privacy is not breached according to Federal Register Vol. 40, #127 Part IV (Title 42, Ch. 1, Part 2, Subpart D)

Appendix D

Chronic Alcoholism Specialists

The following persons were invited to serve on the panel to develop criteria for differential diagnosis of the chronic recidivist alcoholic:

Leonard Cronkite, M.D.
President
Medical College of Wisconsin
Wauwatosa, Wisconsin
(Panel Chairman)

Roland Herrington, M.D.
DePaul Rehabilitation Hospital
Milwaukee, Wisconsin

Donald Ottenberg, M.D.
Executive Director
Eaglesville Hospital
Eaglesville, Pennsylvania

Mr. Gus Oki
Addiction Research Foundation
Toronto, Ontario
Canada

Mr. John Steiger
DePaul/Belleview Health Care Center
Milwaukee, Wisconsin

Ms. Connie McClure, R.N., B.S.
Milwaukee, Wisconsin

Richard Wiesen, M.D.
Milwaukee County Mental Health Center
Milwaukee, Wisconsin

Ms. Anne M. Konar
Executive Director
Cee's Manor
Chicago, Illinois

James A. Halikas, M.D.
Director of the Division of
Alcoholism and Chemical Dependency
Department of Psychiatry
Medical College of Wisconsin

Arthur Wilson, Ph.D.
VA Medical Center
Wood, Wisconsin

Jack Ladinsky, Ph.D.
Department of Sociology
University of Wisconsin
Madison, Wisconsin

Mr. Virgil Williams
Inner City Council on Alcoholism
Milwaukee, Wisconsin

103

Appendix E

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
Chronic "Revolving-Detox-Door" Alcohol Abuser
Screening Instrument

ID:_____________
Year of Birth:_____________
Gender:_____________
Co. of Residence:_____________

Known Chronic Revolving Door Client ( )
Non-Chronic Client .... ( )

(Consider the past year)

1.	Utilizing clinical records or the results of a physician's or assessment counselor's diagnosis, rate the degree of alcohol dependency (Actual diagnosis ______________________________)	Chronic alcohol dependency (3)	acute alcohol depend. (2)	problem drinking, no depend. (1)	no alcohol problem (0)
2.	Number of times medically screened/examined as a result of being intoxicated (#______)	8 or more (3)	5-7 (2)	3-4 (1)	2 or less (0)
3.	Number of episodes medically detoxed (#______)	5 or more (3)	3-4 (2)	2 (1)	1 or less (0)
4.	Number of episodes non-medically detoxed (#______)	8 or more (3)	5-7 (2)	3-4 (1)	2 or less (0)
5.	Actual or attempted committments or confinements (over 5 days) to a program or facility as a result of his/her alcohol problem (#______)	3 or more (3)	2 (2)	1 (1)	0 (0)
6.	Admissions Inpatient Treatment, Outpatient Treatment, Halfway House, Extended Care, etc. as a result of his/her alcohol problem (#______)	5 or more (3)	3-4 (2)	1-2 (1)	0 (0)
7.	Injuries, illnesses, or complications related to his/her alcohol problem such as: broken bones, emphyzema, frostbite, hypertension, memory loss, drug abuse, concussion, liver disease, gashes, burns, ulcers, a cancer, malnutrition, DT's, seizures, nerve damage, hallucinations, suicide attempts, organ damage, near death experience, etc. (What? ____)	3 or more (3)	2 (2)	1 (1)	0 (0)

8.	Illegal acts as a result of his/her alcohol problem such as : stealing, con-games, theft, automobile accident, DWI, assault, rape, robbery, burglary, neglect, child abuse etc. (Which?_____ ______________________________)	3 or more (3)	2 (2)	1 (1)	0 (0)
9.	Negative personal consequences as a result of his/her alcohol problem such as: panhandling, hocking, kicked-out, mugged or rolled, separation from loved one, fighting, abused, indebtedness etc. (Which?_________________________ ______________________________)	3 or more (3)	2 (2)	1 (1)	0 (0)
10.	Years of "chronic" heavy drinking (______months or years)	12 yrs or more (3)	6-11 yrs (2)	1-5 yrs (1)	less than a yr (0)
11.	Binges or several consecutive days of 24 hr. intoxication (How often?_____________________ How long?______________________)	11 or or more (3)	4-10 (2)	2-3 (1)	1 or less (0)
12.	Location of typical drinking such as: publicly visible, room, tavern, etc. (Where?_____________ _____________________________ _____________________________)	frequent Street or public drinking (3)	occasional street or public drinking (2)	tavern drinking (1)	drinking at home (0)
13.	Use of non-beverage alcohol substitutes such as: shaving lotion, HEET, mouthwash, etc. (Which?_____________)	frequently (3)	occasicnally (2)	tavern (1)	seldom (0)
14.	Income during a typical month ($_____)	<$250 (3)	$240-400 (2)	$401-600 (1)	$601+ (0)
15.	Source(s) of income (________ ____________________________ ____________________________ ____________________________)	welfare (3)	disability (2)	cash labor; relatives; friends (1)	retirement; regular employment (0)
16.	Employment status (full-time, part-time, student, homemaker, retired, disabled, unemployed, etc.)_________________________ ____________________________ ____________________________	long duration of unemployment (3)	numerous jobs; recently unemployment (2)	part-time; seasonal (1)	disabled; student; full-time; retired; homemaker (0)
17.	Frequency of contact with family or relatives (# of times per month _________)	0/mo (3)	1/mo (2)	2-3/mo (1)	4 or more per mo. (0)

18.	If he/she were to go to jail or the hospital for a long time is there someone who would visit him/her regularly?	no (3)	one person (2)	two persons (1)	3 or more persons (0)
19.	Affiliation with other alcoholics (e.g. bottle gang; tavern crowd; close friends; etc.) Which?______	all close relation- ships with alcohol abusers (3)	most close relation- ships with alcohol abusers (2)	some of his/her close relation- ships with alcohol abusers (1)	none (0)
20.	Personal hygiene and cleanliness (e.g. body odor; teeth; soiled clothes; etc.)________________	poor (3)	fair (2)	good (1)	very good (0)
21.	No. of days during a typical week when he/she has at least one square meal (# of days __________ Where do you obtain the meal? ____________________)	0-3 days (3)	4-5 days (2)	6-7 days (1)	typically more than 1 sq. meal each day (0)
22.	Months during the year has permanent residence which he/she owns or pays rent? (Where?____________________ ______________________________)	only 3 months or less (3)	4-8 months (2)	9-11 months (1)	Entire year (0)
23.	Check records if available, for psychological problems such as paranoia, depression, anxiety, jealousy, hostility, seclusiveness, etc. (Which?_____________________)	severe problem (3)	moderate problem (2)	slight problem (1)	none (0)
24.	Evidence from records of brain damage (What?__________________ ______________________________)	severe pathology (3)	moderate pathology (2)	slight pathology (1)	none (0)
25.	Church attendance?	never (3)	seldom (2)	occasion- ally (1)	frequent (0)
26.	Willingness to accept his/her powerlessness over alcohol problem	total denial (3)	much denial (2)	some denial (1)	accept- ance (0)
27.	Willingness to accept help to solve alcohol problem?	total refusal (3)	much unwilling- ness (2)	some unwilling- ness (1)	accept- ance (0)

Rater's Assessment:

Definitely a chronic revolving door alcohol abuser ( )
Probably a chronic revolving door alcohl abuser ... ( )
Is not a chronic revolving door alcohol abuser .... ( )

Comments: ____

Appendix F

CRITERIA USED TO EVALUATE SYSTEMIC END-ORGAN DAMAGE TO THE CRA IN THE SSDI AND SSI PROGRAMS

There are three areas in which medical criteria are used to evaluate a CRA's systemic end-organ damage: 1) liver dysfunction, 2) peripheral nerve damage resulting in neuropathy, and 3) central nervous system disorder resulting in chronic brain syndrome. Each of these areas is considered below.

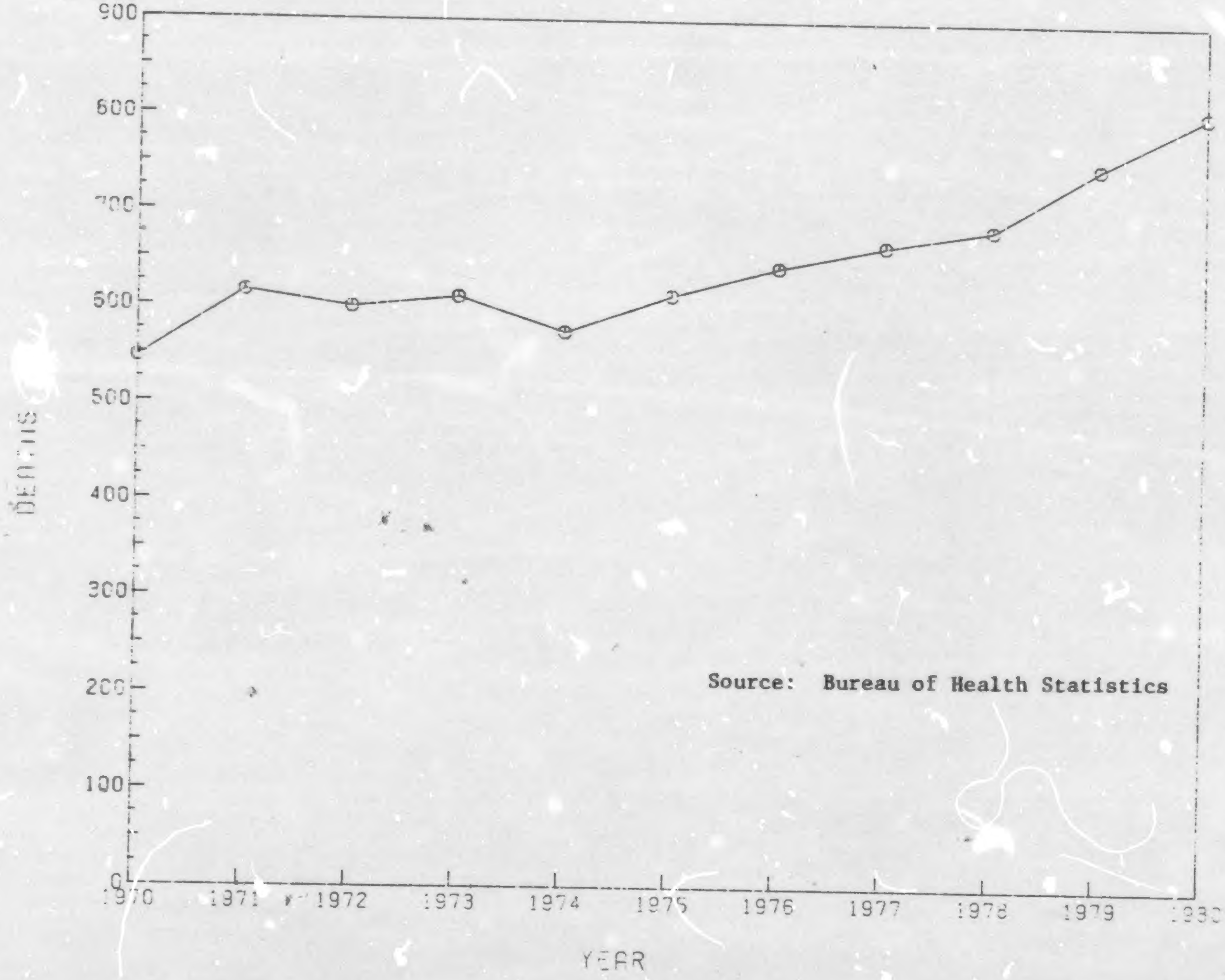
The criteria to assess chronic liver disease involves five considerations. First, the existence of esophageal varices, demonstrated by x-ray or endoscopy (with a documented history of massive hemorrhage attributable to those varices); Second, the performance of a shunt operation for esophageal varices; Third, serum bilirubin readings of 2.5 mg. per deciliter (100 ml.) or greater persisting on repeated exminations for at least five months; Fourth, hepatic encephalopathy which will be discussed later under chronic brain syndrome; and Fifth, the confirmation of chronic liver disease by liver biopsy with one of the following factors being present: 1) Ascites not attributable to other causes, recurrent or persisting for at least three months, demonstrated by abdominal paracentesis or associated with persistent hypoalbuminemia of 3.0 gm. per deciliter (100 mg.) or greater on repeated examinations for at least three months. 3) Hepatic necrosis or inflammation, persisting for at least three months, documented by repeated abnormalities or prothrombin time and enzymes indicative of hepatic dysfunction.

Peripheral nerve damage resulting in peripheral neuropathy is assessed based on the degree of disorganization of motor function in spite of prescribed treatment. To meet this criteria there must be significant and persistent disorganization of motor function in two extremities, resulting in sustained disturbance of gross and dexterous movements, or gait and station.

The assessment of the extent of central nervous system dysfunction resulting in chronic brain syndrome is assessed by two criteria, both of which must be met for severity to be established. The first criteria is that there must be a resulting persistence of marked restriction of daily activities, constriction of interests, deterioration of personal habits and seriously impaired ability to relate to other people. The second is that there must be a demonstrated deterioration in intellectual functioning, manifested by persistence of one or more of the following clinical signs: First, marked memory defect for recent events; or, Second, impoverished, slowed, perseverative thinking with confusion or disorientation; or, Third, labile, shallow or course affect.

Appendix G

WISCONSIN ALCOHOL RELATED DEATHS



Source: Bureau of Health Statistics

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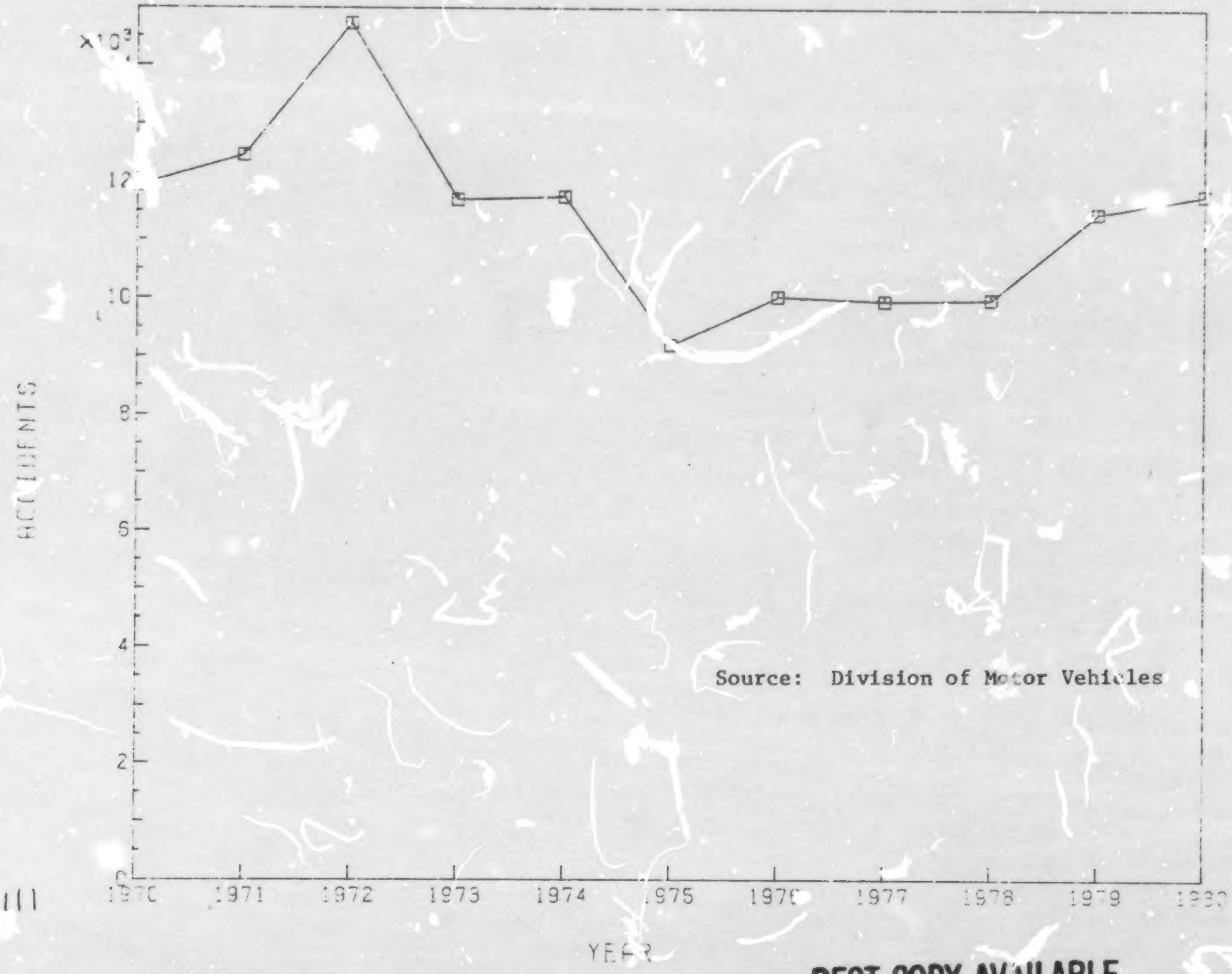
WISCONSIN ALCOHOL RELATED TRAFFIC ACCIDENTS



Source: Division of Motor Vehicles

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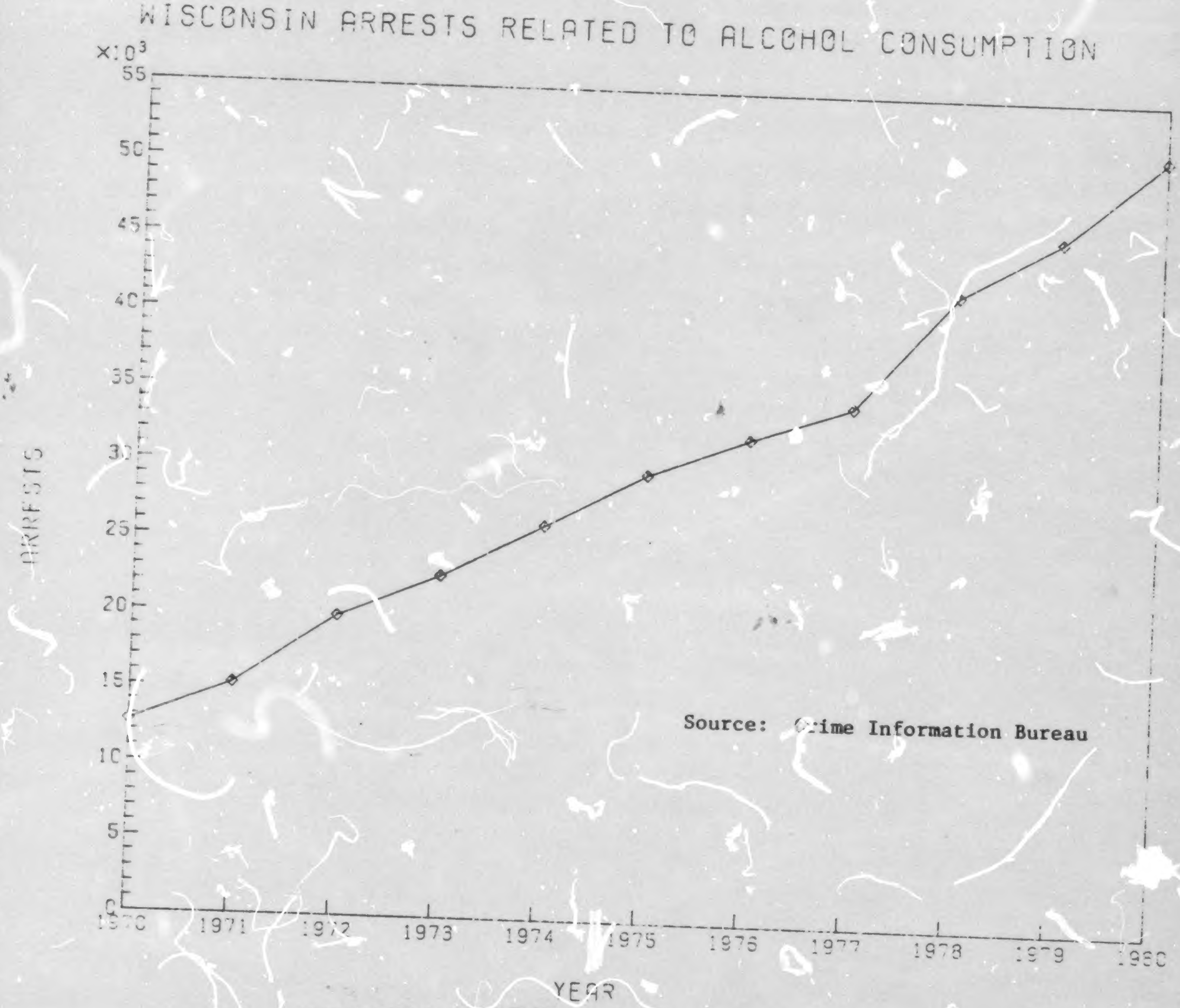

Source: Crime Information Bureau

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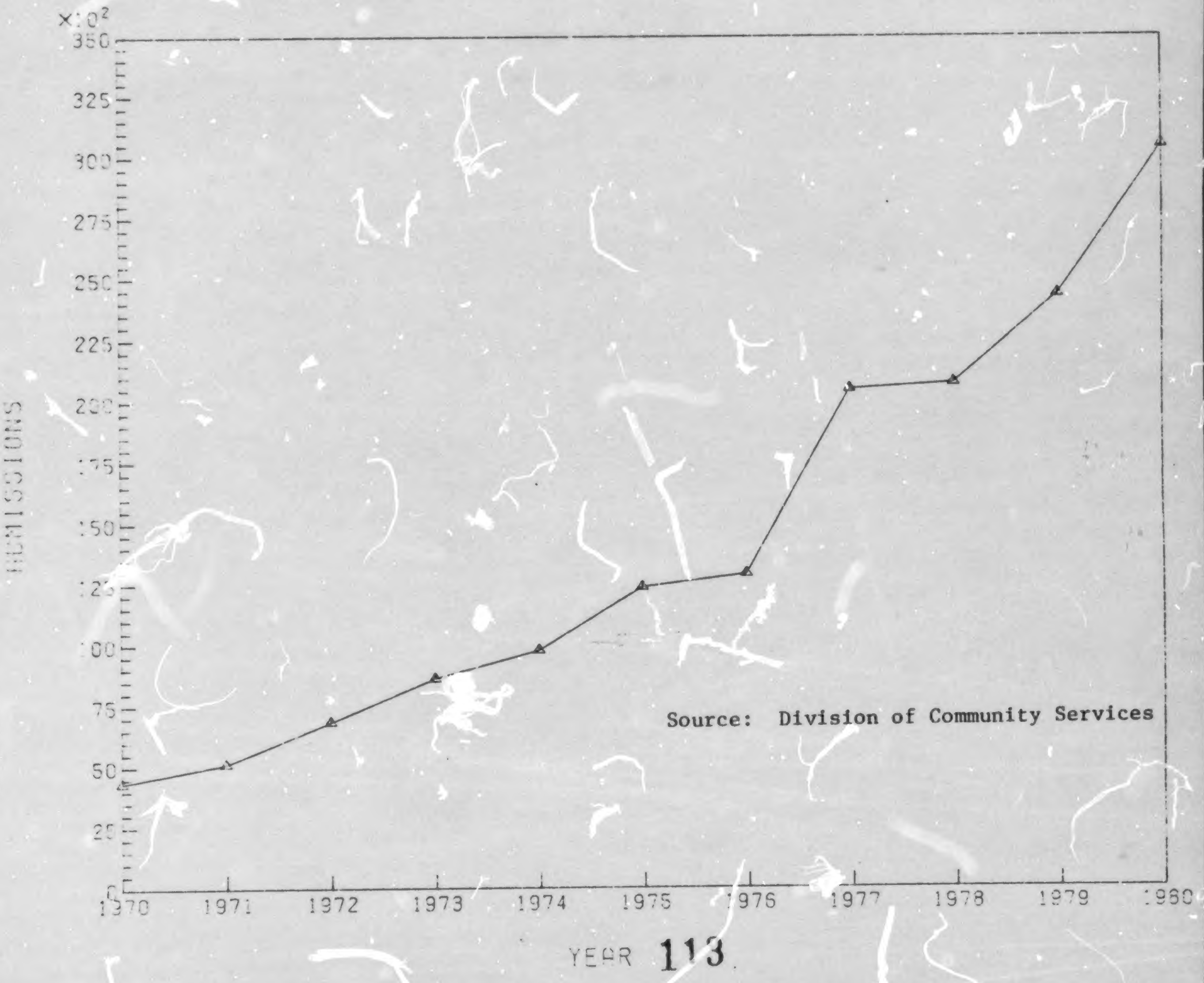
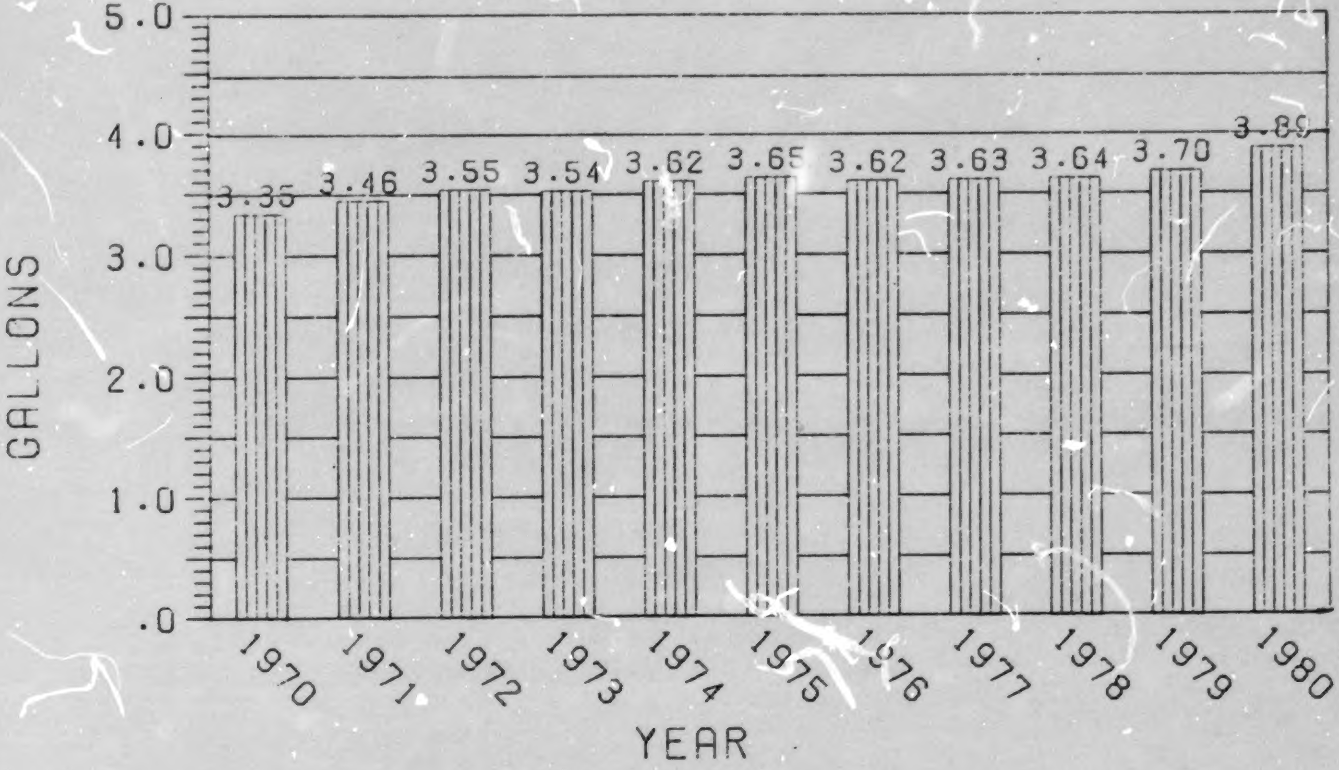
WISCONSIN CITIZENS ADMITTED TO ALCOHOL ABUSE TREATMENT



Source: Division of Community Services

PER ADULT CAPITA ALCOHOL CONSUMPTION IN WI*



* Absolute Alcohol

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Source: WI Dept. of Revenue

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Appendix H

To Establish Protective Custody

1. Establish USE of alcohol or WITHDRAWAL from alcohol
    - a. History from family and others
    - b. Odor of alcohol
2. Establish
    - a. UNCONSCIOUSNESS or
    - b. INABILITY TO MAKE A RATIONAL DECISION
3. RATIONAL DECISION INDICATORS
    - a. Extreme physical debilitation
    - b. Harm to self
        - ...suicide
        - ...inappropriate use of vehicle
        - ...acute mental incompetence*
        - ...inability to maintain erect posture or to ambulate without assistance
        - ...severe, acute illness
    - c. Harm to Others
        - ...homicide
        - ...family fights
        - ...agitation, combativeness
        - ...inappropriate vehicle use
        - ...other
    - d. Harm to Property
        - ...destruction of walls, windows, telephones, etc.

*Disorientation in time, place, person or delusional/hallucinatory behavior

By Dorothy Houden, Bureau of Alcohol and Other Drug Abuse - February, 1980

MATERIAL FOR USE BY BAODA ON INCAPACITATION

A guideline for the implementation of Wisconsin statutes on incapacitation by alcohol.

Wisconsin Stats. 51.45(2)(d) Incapacitated by alcohol.

> (d) "Incapacitated by alcohol" means that a person, as a result of the use of or withdrawal from alcohol, is unconscious or has his or her judgement otherwise so impaired that he or she is incapable of making a rational decision, as evidenced objectively by such indicators as extreme physical debilitation, physical harm or threats of harm to himself or herself or to any other person, or to property"

The information to be used in determining the presence of incapacitation by alcohol is derived primarily from the HISTORY and the PHYSICAL EXAMINATION.

Important items in the history can come from friends, relatives, passersby, and the police as well as from the patient or from the patient's previous records. The physical examination can provide objective evidence of the level of intoxication or withdrawal and of potentially serious complications.

A checklist for determination of Incapacitation by Alcohol based on the history and the physical examination (check yes/no for each item).

	YES	NO
I. Is there evidence of ALCOHOL-RELATEDNESS based on:		
A. A current drinking episode?	____	____
AND/OR		
B. Withdrawal from alcohol?	____	____

II. Is the person:		
A. Unconscious?	____	____
OR		
B. Incapable of making a rational decision?	____	____
If unable to make a rational decision is this based objectively on:		

		YES	NO
1.	Extreme physical debilitation?	____	____
2.	Physical harm to:		
	a. Self?	____	____
	b. Other persons?	____	____
	c. Property?	____	____
3.	Threat of physical harm to:		
	a. Self?	____	____
	b. Other persons?	____	____
	c. Property?	____	____

A YES response in both Box I and II of the checklist signifies the presence of "Incapacitated by alcohol". Note that chronic alcoholism per se is not an element of the check list.

What happens to the person who is assessed as "Incapacitated by Alcohol?"

(d) A person who by examination pursuant to par (c) is found to be incapacitated by alcohol at the time of admission, or to have become incapacitated at any time after admission, shall be detained at the appropriate facility for the duration of the incapacity but may not be detained when no longer incapacitated by alcohol, or if the person remains incapacitated by alcohol for more than 72 hours, after admission as a patient, exclusive of Saturdays, Sundays and legal holidays, unless he or she is committed under sub. (12). A person may consent to remain in the facility as long as the physician or official in charge believes appropriate.

Note that there is a specified maximum period for detaining a person who is "incapacitated by alcohol" and that this period is measured from time of admission and not from the time of the onset of the incapacitation.

By Dorothy Houden - BAODA - July, 1980
Dr. Joseph Benforado - U.W. Department of Medicine
Paul Harris - Attorney

HSS 61.58 SOCIAL SETTING DETOXIFICATION PROGRAM. A social setting detoxification program provides treatment-oriented service which does not include direct medical services. This non-medically oriented program observes and monitors intoxicated individuals who are ambulatory and not in need of major emergency medical or psychological care. The services are provided in a supportive setting and include observation, nourishment and emotional support.

(1) REQUIRED PERSONNEL. (a) At least one trained staff person shall be on duty 24 hours per day, 7 days a week, with a minimum ratio of one staff for every 8 clients present.

(b) An alcohol and drug abuse counselor shall be available 24 hours per day, 7 days a week.

(c) A physician shall be available on a 24-hour basis.

(2) PROGRAM OPERATION. (a) An individual shall be medically screened prior to admission to a non-medical detoxification program.

(b) No individual shall be admitted:

1. Whose behavior is dangerous to staff or other clients;

2. Who requires professional nursing care;

3. Who is incapacitated by alcohol and needs protective custody as required under s.51.45(11), Stats.;

4. Who requires restraints;

5. Who requires medical care; or

6. Who requires medication normally utilized for the detoxification process.

(c) The client shall be observed and his or her condition recorded by trained staff at intervals no greater than every 30 minutes during the first 12 hours after admission.

(d) There shall be a written agreement with a general hospital for the provision of emergency medical treatment of clients. Escort and transportation shall be provided to the client requiring emergency medical treatment.

(e) There shall be a written policy and procedure developed, in consultation with a physician, which provides for emergency treatment as necessary.

(f) The program shall not directly administer or dispense medications.

1. A client may receive medication only as prescribed by the client's personal physician.

2. When a client has been prescribed medication or admitted with prescribed medications and program staff believe use of these medications would not be appropriate to a client's needs or supportive of the program, such a client shall be referred for further medical evaluation to a more appropriate facility. A record of the transfer and reasons for the transfer shall be kept.

(g) There shall be a written plan for referral to other treatment or care which involves significant others wherever possible.

(h) Escort and transportation shall be provided as needed.

Appendix J

State of Wisconsin \ DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF COMMUNITY SERV
1 WEST WILSON ST
MADISON WISCONSIN 5

April 27, 1981

Roland Herrington, M.D.
De Paul Rehabilitation Hospital
4143 South 13th Street
Milwaukee, Wisconsin 53221

Dear Dr. Herrington:

The Steering Committee of the Department of Health and Social Services Long-Term Support Initiative, Task Assignment #1.11, Chronic Alcoholism and Other Drug Abuse, would like to request that the Alcohol and Other Drug Abuse Committee of the State Medical Society recommend to the full State Medical Society the following resolution:

> "Therefore be it resolved that the State Medical Society requests that the U.W. Medical School and the Medical College of Wisconsin immediately implement required curricula hours in alcohol and other drug abuse."

Apparently, some ongoing concern has been raised about the curricula being provided only on a sporadic basis.

Thank you for your cooperation in this matter.

Sincerely,

Dorothy Houden

Dorothy Houden, Co-Chairman
Long-Term Support Initiative

John W. Vick

John W. Vick, Co-Chairman
Long-Term Support Initiative

DHJWVmlb

cc: Larry Monson/Philip McCullough
Vincent Ritacca

Appendix K

Division of Community Services September 29, 1981

To: Paula Possin
Department of Regulation and Licensing
Bureau of Nursing

DH

From: Dorothy Houden/John Wick, Chairpersons
Long Term Support Steering Committee
Bureau of Alcohol and Other Drug Abuse

Re: TASK ASSIGNMENT #1.11 - DEPARTMENT OF HEALTH AND SOCIAL SERVICES
PLANNING GUIDELINE #1, LONG TERM SUPPORT
"CHRONIC RECIDIVIST ALCOHOLISM AND OTHER DRUG ABUSE"

Recently, the Department of Health and Social Services issued the above referenced Task Assignment (attached).

The Division of Community Services, Bureau of Alcohol and Other Drug Abuse, has been given primary responsibility for carrying out the assignment with appropriate involvement from other portions of DHSS, the University of Wisconsin, the Department of Vocational, Technical, and Adult Education, other state agencies, and AODA interest groups and service consumers.

The purpose of this communication is to:

1. Direct your attention to objective 7: the development of a plan to promote the adequate training of health care students and practitioners in chronic alcoholism and other drug abuse.

2. To solicit your vital input in determining which schools of nursing in Wisconsin currently include chronic alcoholism and other drug abuse in their curriculum hours.

The steering committee for Task Assignment #1.11 is grateful to the Bureau of Nursing for its cooperation in this assignment.

Upon completion of this request please forward the results to:

Dorothy Houden
Bureau of Alcohol and Other Drug Abuse
1 West Wilson - Room 434
P.O. Box 785
Madison, WI 53707

DHJVrv

attachment

cc Long Term Support Steering Committee
Larry W. Monson/Phil McCullough
Roland McCauley, BAODA

Division of Community Services June 8, 1981

To: Regional Directors
Regional AODA Program Consultants
Community Service Boards

From: Burton A. Wagner
Administrator

Re: TASK ASSIGNMENT #1.11 - DEPARTMENT OF HEALTH AND SOCIAL SERVICES
PLANNING GUIDELINE #1, LONG TERM SUPPORT
"CHRONIC RECIDIVIST ALCOHOLISM AND OTHER DRUG ABUSE"

Recently, the Department of Health and Social Services issued the above referenced Task Assignment (attached).

The Division of Community Services, Bureau of Alcohol and Other Drug Abuse, has been given primary responsibility for carrying out the assignment with appropriate involvement from other portions of DHSS, the University of Wisconsin, the Department of Vocational, Technical, and Adult Education, other state agencies, and AODA interest groups and service consumers.

The purpose of this communication is to:

1. Direct your attention to objective #1(b): "Inventory of existing services and assessment of the need for them..."

2. To solicit your vital input in completing the inventory.

The attached form is our vehicle for obtaining a current inventory of existing facilities and services for the chronic recidivist and other drug abuser.

Upon your completion of the inventory, please forward to:

Chronic Recidivist Service Inventory
Bureau of Alcohol and Other Drug Abuse
1 West Wilson Street
P.O. Box 7851
MADISON WI 53707

by June 26, 1981. It is important that we obtain a 100% response from this survey, so please consider filling it out and returning it to us by the closing date.

The results will be published in upcoming issues of the BAODA News Memo.

Attachments

cc: Douglas Nelson
John Erickson
John Vick/Dorothy Houden
Don Warnke

CHRONIC RECIDIVIST ALCOHOL AND OTHER DRUG ABUSER FACILITY AND SERVICES INVENTORY

INSTRUCTIONS: Please check ( ) or provide descriptive information to each item to the best of your knowledge. For the purposes of this form, we are broadly defining the chronic recidivist as:

"Any individual who has been assessed as having an alcohol or drug abuse problem and has repeatedly received public AODA services resulting in little long-lasting change in behavior."

---

1. What is the name of your Community Service Program (51.42 Board) or Human Services Department? ______________________________

2. Does your CSP or HSD provide or contract for services to the chronic recidivist? (Check one)

( ) Yes
( ) No - Please explain: ______________________________
____
____
____

3. About how many chronic recidivists are there in your service area? ____

4. List only the agencies or facilities that have provided special services or care specifically to the chronic recidivist in the past year. Leave blank if none exist.

Services	Agencies or Facilities
Intervention	______________________________
Emergency	______________________________
Outpatient	______________________________
Inpatient	______________________________
Day Services	______________________________
Sheltered Employment	______________________________
Extended Care	______________________________
Special Living Arrangements	______________________________
Methadone Maintenance	______________________________
Other	______________________________

5. About how many chronic recidivists can the above agencies (Item #4) or facilities serve or care for in a year's time? (You may provide actual or estimated volume figures) ____________

6. What typically happens to the chronic recidivist during the hours, days, or weeks following a pick-up by police or admittance to detox? (Include legal procedures; services received; outcome of services; and other impressions)

7. On a scale from one to ten, how effective is this approach? (Item #6)

1____ 2____ 3____ 4____ 5____ 6____ 7____ 8____ 9____ 10
Very Ineffective — Very Effective

8. Can you recommend some more effective approaches? (Please be specific)

9. Are there any other comments you would like to make? ____________

Thank you.

Appendix M

______Office Number
Project 1371
July, 1981

University of Wisconsin-Extension
Wisconsin Survey Research Laboratory
COVER SHEET

CHRONIC ALCOHOLIC RECIDIVIST PROJECT STAFF INTERVIEW

1. I: IS THIS CALL... /1. Completed/ /2. Any other result/ (TO 999)

2. May I speak with (NAME OF R)?

/1. Yes: first contact with respondent/

/2. Yes: respondent contacted before/ (TO Q 6)

/3. No: respondent not available/ (TO Q 7)

/4. No: respondent not at this number/ (TO Q 5)

/9. Refused/ (TO 999)

3. I'm (YOUR NAME) calling from the University of Wisconsin's Survey Research Laboratory for the State's Bureau of Alcohol and Other Drug Abuse. Do you remember receiving a letter from us about this survey?

/1. Yes/ /2. No/

4. The Bureau of Alcohol and Other Drug Abuse asked us to interview staff members who worked with the Chronic Alcoholic Projects during 1979 in order to evaluate the project's strengths and weaknesses. Could we take an interview with you now?

/1. Yes/ (TO SCHEDULE) /2. R cannot start now/ (TO Q 7) /3. R denies eligibility/ (END: TO 999) /9. Refused/ (TO 999)

5. Where can I reach (NAME OF R)?

Phone #: ______________________ /9. Informant doesn't know/ (TO 999)

Other information: ______________________________________

____

(TO 999)

6. (EXPLAIN AS NECESSARY) I would like to interview you now.

/1. R does not object/ (TO SCHEDULE) /2. R cannot start now/ (TO Q 7) /3. R denies eligibility/ (END: TO 999) /9. Refused/ (TO 999)

7. When would be the best time to phone (NAME OF R) and whom should we ask for when we call again?

APPT.?	WHEN TO CALL			COMMENTS
	NO.	DAY	TIME	
/Yes/				
/Yes/				
/Yes/				

999. CALL INFORMATION. DO NOT MAKE MORE THAN SIX CALLS WITHOUT SPECIFIC APPROVAL OF A FIELD SUPERVISOR.

INTER- VIEWER	CALL NO.	MO	DAY	TIME CALL...		RESULT CODE	COMMENTS
				STARTED	ENDED		
	1						
	2						
	3						
	4						
	5						
	6						

DO NOT MAKE MORE THAN SIX CALLS WITHOUT SPECIFIC APPROVAL OF A FIELD SUPERVISOR.

	7						
	8						
	9						
	10						
	11						
	12						
	13						
	14						
	15						

__________ Office Number
Project 1371
July, 1981

University of Wisconsin-Extension
Wisconsin Survey Research Laboratory

CHRONIC ALCOHOLIC RECIDIVIST PROJECT STAFF INTERVIEW

Before we begin, I want to emphasize that the Wisconsin Bureau of Alcohol and Other Drug Abuse has promised that the information you give will be kept confidential. All the data provided by you and about 30 other individuals we are interviewing for the Bureau will be summarized. Neither your name nor the project you worked in will be identified by the Bureau with any information you provide to Bureau personnel through this interview. If we ask any questions which you feel unqualified to answer, or—for your own reasons—do not care to answer, please feel free to skip them.

1. First, what position did you have with the Chronic Project? (E.g., director, cook, halfway house manager, etc.)

   POSITION: ____

2. How many months did you work with the project? # MONTHS: ________

3. As far as you know, about how many clients in all were served by the project? (Estimate, if necessary)

   # CLIENTS: ________

4. Of this total number of clients, how many would you say were totally rehabilitated?

   #: ________

5. How many were mostly rehabilitated? #: ________

6. How many were somewhat rehabilitated? #: ________

7. And, how many were not rehabilitated at all? #: ________

8. What kinds of services were provided by the project to chronic clients? (Anything else?) ______________________________

   ____
   ____
   ____
   ____
   ____

Interviewer: ______________________ Sample #: ______________

Date: ______________ Time Started: ______________

9. In addition to grant funds and funds from Fifty-one Forty-two, what kinds of financial support were available to help the project provide services to the chronic alcoholic?

10. To the best of your knowledge, is the chronic project you were involved with still operating in its entirety?

/1. Yes/ (TO Q 11) /2. No/ ↓ /7. Don't know/ (TO Q 11)

10a. Is most of the project still operating?

/1. Yes/ (TO Q 11) /2. No/ ↓ /7. Don't know/ (TO Q 11)

10b. Is it operating at least to some extent?

/1. Yes/ ↓ /2. No/ (TO Q 10d) /7. Don't know/ (TO Q 11)

10c. In your opinion, why was the project reduced to the present level?

(TO Q 11)

10d. Then, the project has been terminated completely?

/1. Yes/ ↓ /2. No/ (GO BACK TO Q 10c) /7. Don't know/ (TO Q 11)

10e. In your opinion, why was the project terminated? ______________________

11. As you see it, what are some useful ways to get chronic alcoholics to begin a program and start receiving special services designed for them? (Anything else?) ______________________

12. What are some useful ways to get chronic alcoholics to stay with a program and continue receiving special services designed for them? (Anything else?) ______________________

13. Recognizing that many things can be involved, what things do you feel make really important contributions to the successful rehabilitation of a chronic client? (Anything else really important?)

14. On the other hand, what things do you feel that--if present--have a major negative effect on the chances for a successful rehabilitation? (Anything else?)

15. What types of treatment do you feelare most effective with the typical chronic alcoholic...a day service, or outpatient counseling, or some other services?

/1. Day service/ /2. Outpatient counseling/ /3. Other services/ (TO Q 15b)

15a. Why do you feel this way? ______________________________

(TO Q 16)

15b. What other kind of treatment do you feel is most effective with the chronic alcoholic, and why?

16. With respect to the chronic alcoholic, do you feel group counseling techniques are very effective, effective, or ineffective?

/1. Very effective/ (TO Q 17) /2. Effective/ (TO Q 17) /3. Ineffective/ (TO Q 17) /4. Depends/ /7. Don't know/ (TO Q 17)

16a. On what does it depend? ______________________________

130

17. Are there any other comments you would like to make about the chronic project or this interview?

* * * * * * * * * * * * * * * * * * TERMINATE *

Time Interview Ended: ________________

Sex of Respondent: /1. Male/ /2. Female/

COMMENTS: ________________

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Fact Sheet:

Appendix N

NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

State Dedicated Alcohol Taxes (January 1, 1980)

Following is a summary of laws by State pertaining to taxes levied on the purchase of alcoholic beverages, the proceeds of which are dedicated to the treatment or prevention of alcoholism. (Citations refer to the specific section or sections in the State statutes or code where the law is found.)

Alabama	In addition to all other taxes there is levied a tax at the rate of 10 percent of the selling price of all spirituous or vinous liquors, one-half of which is to be used by various programs including alcoholism programs. (28-3-201, 28-3-202)
Arkansas	This law imposes a $25 fine (in addition to any other penalty) on persons convicted of driving while intoxicated. These proceeds are to be placed in the Alcohol Safety Rehabilitation Programs Fund. (75-1029.5)
Idaho	This law places a specified tax on liquor; the proceeds from this tax are to be placed in the Liquor Control Fund and are to be used for alcohol treatment and rehabilitation programs. (23-402 through 23-404)
Indiana	An additional fee of $30 is required for retailer's and dealer's permits and is to be used for alcoholism treatment, prevention, and rehabilitation programs. (7-4-3-1)
Iowa	A specified portion of the license fee for manufacturers, storage and wholesale distributors of alcoholic beverages shall be appropriated to local county authorities and shall be deposited in the county's institutions fund for the care and treatment of alcoholics. (123.36)
Kansas	Fifty percent of revenues from private club license fees is to be deposited in the State alcoholic treatment fund. (41-26-22) Ten percent of revenue from tax on alcohol and spirits is to be deposited in the State or community alcoholism and intoxification programs fund. (41-501)
Maryland	Allegany county allocates 20 percent of State taxes on alcoholic beverages and license fees for alcoholic beverage dispensaries, collected in that county, for alcoholism treatment and rehabilitation programs. (Adopted by Motion of County Commissioners.)
Michigan	A specified percentage of retailer's license fees collected in the State shall be credited to a special fund for the purpose of promoting programs for prevention, rehabilitation, care, and treatment of alcoholics. (436.47) In addition to all taxes imposed by law, there is imposed and levied a specific tax equal to 1.85 percent of the total selling price of spirits; the tax is to be used for the treatment of alcoholics. (436.131)
Mississippi	A 3 percent tax is placed on alcohol products to be used solely for alcoholism treatment and rehabilitation programs. (27-71-7)
Montana	A percentage of the license tax on liquor establishments is to be deposited in a fund for alcoholism treatment, prevention, and rehabilitation. (16-1-404, 16-1-408)
North Carolina	Seven percent of liquor profits and a $.05 per bottle tax provide funds for education purposes relating to the use of alcohol and rehabilitation of alcoholics. (18A-17)
Ohio	One-half of one percent of liquor permit fees (matched by an equal amount from the State general fund) is allocated for alcoholism treatment control programs. (4301.10, 4301.30 4301.02, et. seq.)

Oregon	One-third of manufacturers' excise taxes on alcoholic beverages is to be allocated to the State and counties for alcoholism programs. (430.380)
South Carolina	A specified percentage of revenue received from the sale of liquor shall be returned to the counties on a per capita basis to be used for education purposes relating to the use of alcohol and rehabilitation of alcoholics. (61-5-150)
South Dakota	A tax of $.30 per barrel on beer and $.05 per gallon on liquor shall be deposited in a fund for alcoholism programs. (35-5-21.3)
Tennessee	Two percent of taxes on beer and light liquor shall be dedicated to alcoholism treatment, rehabilitation, and prevention programs. (57-217)
	Specified percentage of taxes collected on distribution and sale of hard liquor shall be allocated to alcoholism programs - 1978-1979 fiscal year 1.16 percent allocated; 1979-1980 amount allocated is 2.33 percent; 1980-1981 amount allocated is 3.5 percent. (57-135)
Virginia	A specific portion (15 percent) of State liquor taxes shall be appropriated for liquor programs. (415.1)
Washington	Revenues from Class H license fees in excess of $1 million per biennium plus 20 percent of Class A-F license fees accrue for alcoholism programs. (66.08.180)
	Cities and counties may share in the use of other city or county alcoholism programs or facilities if they contribute 2 percent of their share of liquor taxes to support those shared programs or facilities. (70.96)
West Virginia	Price of alcoholic beverages shall be increased to produce an additional annual revenue of $1 million on an annual volume of business for the care and treatment of alcoholic people. (60-3-9C)
New York	Increase alcohol beverage tax by 1%.
Nebraska	Increase alcohol beverage tax to assist with A/DA program funding.
Indiana Florida California	Passed legislation in 1980/81. Money set aside for AODA programs from increased alcohol beverage taxes or liquor license fees.

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